Cynulliad Cenedlaethol Cymru
National Assembly for Wales

Cofnod y Trafodion
The Record of Proceedings

Y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon

The Health, Social Care and Sport Committee

02/02/2017

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Cofnodir y trafodion yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir trawsgrifiad o'r cyfieithu ar y pryd. Lle y mae cyfranwyr wedi darparu cywiriadau i'w tystiolaeth, nodir y rheini yn y trawsgrifiad.

The proceedings are reported in the language in which they were spoken in the committee. In addition, a transcription of the simultaneous interpretation is included. Where contributors have supplied corrections to their evidence, these are noted in the transcript.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Rhun ap Iorwerth Bywgraffiad|Biography	Plaid Cymru The Party of Wales
Dawn Bowden Bywgraffiad|Biography	Llafur Labour
Jayne Bryant Bywgraffiad|Biography	Llafur Labour
Angela Burns Bywgraffiad|Biography	Ceidwadwyr Cymreig Welsh Conservatives
Caroline Jones Bywgraffiad|Biography	UKIP Cymru UKIP Wales
Dai Lloyd Bywgraffiad|Biography	Plaid Cymru (Cadeirydd y Pwyllgor) The Party of Wales (Committee Chair)
Julie Morgan Bywgraffiad|Biography	Llafur Labour
Lynne Neagle Bywgraffiad|Biography	Llafur Labour

Eraill yn bresennol
Others in attendance

Naomi Alleyne	Cyfarwyddwr, Gwasanaethau Cymdeithasol a Thai, Cymdeithas Llywodraeth Leol Cymru Director, Social Services and Housing, Welsh Local Government Association
Neil Ayling	Prif Swyddog, Gwasanaethau Cymdeithasol Sir Fflint a Llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru Chief Officer, Social Services at Flintshire and President of the Association of Directors of Social Services Cymru

Julie Boothroyd	Pennaeth Gwasanaethau Oedolion Sir Fynwy, Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru Head of Adult Services at Monmouthshire, Association of Directors of Social Services Cymru
Dr Llion Davies	
Nick Johnson	Arbenigwr Hwyluso Gofal Dementia, Bwrdd Iechyd Prifysgol Abertawe Bro Morgannwg Dementia Care Specialist Facilitator, Abertawe Bro Morgannwg University Local Health Board
Dr Zahid Khan	
Dr Abby Parish	
Dr Bethan Roberts	
Lin Slater	Cyfarwyddwr Cynorthwyol Nyrsio, Bwrdd Iechyd Prifysgol Aneurin Bevan Assistant Director of Nursing, Aneurin Bevan University Local Health Board
Dr Huw Lloyd Williams	
Dr Suzanne Wood	Ymgynghorydd mewn Meddygaeth Iechyd Cyhoeddus, Bwrdd Iechyd Prifysgol Caerdydd a'r Fro Consultant in Public Health Medicine, Cardiff and Vale University Health Board
Yr Athro/Professor Robin Williams	

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Sarah Hatherley	Y Gwasanaeth Ymchwil Research Service
Gareth Pembridge	Cynghorydd Cyfreithiol Legal Adviser
Claire Morris	Ail Glerc Second Clerk
Sarah Sargent	Dirprwy Glerc Deputy Clerk
Sian Thomas	Clerc Clerk

Dechreuodd y cyfarfod am 09:30.
The meeting began at 09:30.

Cyflwyniad, Ymddiheuriadau, Dirprwyon a Datgan Buddiannau
Introductions, Apologies, Substitutions and Declarations of Interest

[1] **Dai Lloyd**: Croeso yn ffurfiol i gyfarfod diweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yng Nghynulliad Cenedlaethol Cymru. A gaf i estyn croeso i'n tyst—mwy am yr Athro Williams yn y foment—a hefyd estyn croeso i'm cyd-aelodau o'r pwyllgor, gan gyhoeddi y bydd Jayne Bryant ychydig yn hwyr y bore yma? Rydym ni wedi derbyn ei hymddiheuriadau hi am hynny. A allaf i egluro yn bellach fod y cyfarfod yma'n ddwyieithog? Gellir defnyddio clustffonau i glywed cyfieithu ar y pryd o'r Gymraeg i'r Saesneg ar sianel 1 neu i glywed cyfraniadau yn yr iaith wreiddiol yn well ar sianel 2. A allaf i atgoffa hefyd pobl i ddiffodd eu ffonau symudol ac unrhyw offer electroneg arall sy'n debygol o ymyrryd â'r offer darlledu byd eang? A allaf i yn bellach hysbysu pobl nad ydym ni'n disgwyl tân y bore yma, felly dylid dilyn cyfarwyddiadau'r tywyswyr os bydd y larwm yn canu?

Dai Lloyd: Welcome to the latest meeting of the Health, Social Care and Sport Committee here at the National Assembly for Wales. Can I please welcome our witness today—more about Professor Williams in a moment—and can I also welcome my fellow members of the committee? Jayne Bryant will be a little late this morning. We have received apologies from her. Can I explain that the meeting is bilingual? Headphones are available for simultaneous translation from Welsh to English on channel 1 or for amplification on channel 2. Can I please remind you to turn your mobile phones off and any other electronic equipment that may interfere with the broadcasting equipment? Also, can I let you know that we're not expecting a fire alarm? If you do hear the alarm, please follow the directions of the ushers.

09:31

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 1—yr Athro Robin Williams
Inquiry into Medical Recruitment—Evidence Session 1—Professor Robin Williams

[2] **Dai Lloyd**: Felly, symudwn ni ymlaen at eitem 2 a'n ymchwiliad ni i recriwtio meddygol. Dyma'r sesiwn dystiolaeth gyntaf a'n tyst cyntaf ni ydy'r Athro Robin Williams. Croeso mawr ichi—awdur, wrth gwrs, 'Health Professional Education Investment Report on the Single Set of Arrangements'. Mae pawb wedi darllen pob manylyn yn drylwyr iawn. Wrth gwrs, mae gyda ni gyfres o gwestiynau sydd yn mynd i mewn i fanylder y pwnc—rhyw 15 ohonyn nhw dros yr awr nesaf. Felly, bydd angen cwestiynu tyn ac efallai atebion tyn, Robin. Felly, gyda chymaint â hynny o ragymadrodd, a chroeso i'r Athro Robin Williams, a gaf i ofyn i Rhun ddechrau'r cwestiynu? Rhun.

Dai Lloyd: So, can we move on, please, to item 2, our inquiry into medical recruitment? This is the first evidence session and our first witness is Professor Robin Williams. Welcome to you—the author, of course of, 'Health Professional Education Investment Report on the Single Set of Arrangements'. Everyone has read every detail of your report. Of course, we do have a series of questions that look at the detail of the subject—some 15 questions in all, over the next hour. So, we will need to be succinct in our questioning and, perhaps, in the answers as well, if I may say so. So, can I move on now, please, and welcome Professor Williams? Can Rhun please begin the questioning?

[3] **Rhun ap Iorwerth**: Bore da iawn ichi. Croeso atom ni'r bore yma. Os cawn ni ddechrau'n eithaf cyffredinol a mynd yn ôl at y dechrau—dechrau eich rhan chi yn hyn—mi oedd eich gwaith chi'n deillio, wrth gwrs, o adolygiad Evans, ond beth oedd eich dealltwriaeth chi ar y dechrau yna o'r themâu a'r cwestiynau yr oedd disgwyl ichi fynd i'r afael â nhw?

Rhun ap Iorwerth: Good morning and welcome. If we could start quite generally and go back to the beginning—the beginning of your part in all of this—your work stemmed, of course, from the Evans review, but what was your understanding during that initial period of the themes and questions that you were expected to address?

[4] **Yr Athro Williams**: Diolch yn

Professor Williams: Thank you very

fawr. Yr adroddiad Evans ydy'r canllawiau go iawn, ac mae'r adroddiad yna yn un drylwyr, yn ofalus ac mae wedi gwneud ei waith cartref yn hynod o dda. Un o'r argymhellion oedd bod y Llywodraeth yn—y gair ydy '*refresh*' eu strategaeth; rydw i wedi clywed geiriau eraill—a hefyd y dylai fod yna ryw fath o gorff a fyddai'n edrych ar y gweithlu yn y dyfodol ac yn comisiynu, oherwydd yr hyn sydd o'u blaenau nhw. Ar hyn o bryd, rydw i'n meddwl bod y comisiynu yn dibynnu mwy ar beth sydd wedi digwydd yn y gorffennol nag ar yr hyn sydd yn angenrheidiol. So, mi ddylai fod y comisiynu wedi'i wreiddio mewn tystiolaeth yn fwy na hanes.

much. The Evans report would be the guidelines, and that report is very detailed, carefully considered, and his homework was done excellently. One of the recommendations was that the Government should 'refresh' their strategy—I've heard other words used—but also that there should be some kind of body that would look at the workforce required in the future and also would commission training guided by future needs. At present, the commissioning work depends more on what has happened in the past, rather than what is required. So, the commissioning work should be based on evidence of need and not historical figures.

[5] Dyna oedd y dechrau. Wedyn fy meibl i oedd adroddiad Evans ac roeddwn i'n edrych ar y rhan fach yna o'r posibilrwydd o gorff hyd braich—*arm's length*—i edrych ar yr holl agweddau yna.

That was the starting point. Then my bible was the Evans review, and I was looking at that particular part of the report on the possibility of having an arm's-length body to look at all those aspects.

[6] **Rhun ap Iorwerth:** Mi wnawn ni drafod manylion y casgliad y daethoch chi iddo fo, ond, os caf i rŵan neidio i ben draw eich gwaith chi, mi wnaethoch chi argymhelliad ynglŷn â'r corff newydd roeddech chi yn ystyried y byddai'n ateb gofynion yr argymhelliad a gafodd ei wneud yn adroddiad Evans. Yr ymateb, wedyn, i'r casgliad a ddaethoch chi iddo—a oedd hwnnw'n cyd-fynd â'r ymateb cyffredinol a ddaeth yn sgil adroddiad Evans am yr angen am yr un corff?

Rhun ap Iorwerth: We'll discuss the details of the conclusion that you reached later, but, if I could jump to the other end of your work, you made a recommendation regarding the new body that you considered would meet the requirements of the recommendation made in the Evans review. The response, then, to your conclusion—did that correspond to the general response that came from the Evans review on the need for a single body?

[7] **Yr Athro Williams:** Diddorol. Roedd yna gonsyltio ar ôl adroddiad Evans ac mi oedd yna nifer anferth o atebion—ffeil y seis yna. Gwnes i ddarllen y rheini bob un, ac roedden nhw'n mynd o un pegwn, mewn gwirionedd, i'r llall, fel byddech chi'n disgwyl—lot o bobl yn hollol gefnogol, ac eraill ddim mor gefnogol; rhai reit yn erbyn, a dweud y gwir. Wedyn, un o'r *jobs* a oedd gen i i'w wneud oedd trio cael consensws, trio cael un model y byddai pawb yn ei gefnogi ac yn ein galluogi ni i symud ymlaen. Wedyn, un o'r pethau pwysicaf i'w wneud, mae'n debyg, oedd siarad efo cymaint o bobl â phosibl, ac mae'n rhaid i mi ddweud yr oedd yn anferth o bleser gwneud hynny, achos roedden nhw i gyd eisiau dweud eu barn, ac roedden nhw'n gwerthfawrogi cael y cyfle i fynd trwy'r hyn yr oedden nhw yn ei feddwl efo fi.

Professor Williams: Interesting question. There was consultation following the Evans report, and there were very many answers—a huge file of responses was received. I read them all, and opinions basically went from one extreme to the other, as you might expect—many people were very supportive, and others not quite as supportive, and some quite strongly against the idea. One of the jobs I had was to try to get to some sort of consensus on the matter, and have one model that everyone would support that would then enable us to move forward. The most important thing, perhaps, to do was to talk to as many people as possible, and I must say it was a great pleasure to do so, because they were all very keen to give their opinions and they very much appreciated the opportunity to discuss the issues with me.

[8] Yn y diwedd, cawsom ni bawb at ei gilydd i drio cael consensws a phawb tu ôl i'r model, a'r teimlad roeddwn i'n ei gael yr adeg honno oedd bod pawb rŵan yn gefnogol ac yn barod i fynd. Roedd llawer iawn yn dweud, 'Os gwnewch chi plîs symud yn fwy cyflym, achos mae'r amser yn mynd'. Ond rydw i'n gobeithio ein bod ni wedi cael pawb, mwy neu lai, i'w gefnogi. Nid yw'n 100 y cant, ond rwyf i'n meddwl ar y cyfan bod yna gefnogaeth, a chonsensws, go dda.

In the end, we got everybody together to try and reach a consensus, and get everyone to support the model, and the feeling I had at that time was that everyone is by now supportive and ready to move on with this. Many people said, 'Please can you move more quickly on this, because time is passing by?' But I do hope that we have, more or less, got everybody's support. It's not 100 per cent, but I think on the whole we have consensus.

[9] **Rhun ap Iorwerth:** Diolch.

Rhun ap Iorwerth: Thank you.

[10] **Dai Lloyd**: Symud rŵan i statws cyfredol eich adolygiad chi, a hefyd casgliadau eich adolygiad chi, mae gyda Caroline Jones gwestiynau ar hyn.

Dai Lloyd: Moving now to the current status of your review, and also to the conclusions of your review, Caroline Jones has questions on this.

[11] **Caroline Jones**: Diolch, Chair. Could you tell me the current status of the review in terms of formal agreement, and the implementation of the proposals against the timescales suggested in the report?

[12] **Professor Williams**: One of the issues was what kind of body there should be formally. I think what I did, and the panel that helped me—and I must pay tribute to them, because, as I said in the introduction, I'm a novice in NHS matters, so I needed a lot of help—. But what we did was to come up, first of all, with what kind of body is needed. Once we'd done that, then we looked at what kind of structure is in place for that to happen. By far the most suitable in our view was a special health authority, because that can be established without primary legislation, if I'm right—you'll know a lot more about this than I do. So, that was the reason for doing it that way. As I understand it, this can be done by the Welsh Ministers, and, in terms of the target date, I think April 2018 was the date in the report, perhaps with something in shadow form 12 months earlier than that. I think the current situation is that there is now a project director. There's a system in place to look at the various components of setting this up, and it's quite complex because you can't do some things until you've done other things. So, I would be hopeful that it would be in place and fully operational by April 2018.

[13] **Caroline Jones**: Okay. Thank you very much. I'll ask you a couple of questions now. Can you tell me what the key conclusions are of the report, and the suggested areas for prioritising, and how they're going to be—different parts of—and, in different parts of the UK, looking across at the health education teaching in a positive and negative way for the workforce planning, could you tell me please is there anything that has been learnt from this and the increased emphasis on multidisciplinary teams?

[14] **Professor Williams**: Thank you very much for that. So, let me start with the main part. I'm a physicist, so I tend to put things in order, but it starts with: we're all ageing. The health needs are changing. The health service is so good—we have all kinds of things now—we're living longer and longer and we have multiple issues. So, the question is: 15 years down the line,

what kind of healthcare need will there be? Is the workforce that exists now, the pattern of that, adequate for what's coming down the line? Now, the view we took is that, to judge that—. By the way, the health boards and workforce, education and development services are very good on the short-term workforce planning. The first year is good, second year less, third year—. Now, long-term workforce planning is a difficult thing to do. You can't be accurate. But, for sure, you can be more accurate if you have experts looking at it—if you have people who know what kind of health facilities, treatments and so on are down the road. So, that's where it starts. Then, of course, that needs to feed back into the training of the workforce, bearing in mind that, for doctors, it takes a long time before the training is complete. For some others, unlike health [Correction: medicine], it's shorter, so they can respond a lot more quickly. So, that's the main consideration.

[15] Now, part of the problem, I think, in Wales is this. There is a group called the strategic education and development group, which you will know about, where the participants are involved. There is, I thought, often a silo mentality—you know, if you are around the table to defend your own profession, that's not the best way of allocating resources and gaining confidence of the whole community. So, I took the view that this body needs to be independent, not representing silos. You need experts. You need them to be independent. I would suggest that the trawl for members is wider than just Wales. The chairman is crucial, and the chief executive is crucial. The body would work with—not instruct, work with—the health authorities and the universities and all the other stakeholders—the royal colleges, the regulators, and so on. It is vitally important that the people who deliver have confidence in that body. If they don't have confidence, then, you know—. So, that's a crucial thing.

[16] We looked at Northern Ireland. I won't say a great deal about that, because the nurse training is done directly through university, and there is a body that looks after the doctors. England—it's a different situation in England. It's so big. Even the smallest, I think, of their local health authorities is bigger than Wales. So, they had a system where quite a number of things like workforce planning are done centrally, but the delivery is done through the local boards. We had a good look at that, and some of these have worked better than others. Some have worked quite well, others not. The workforce planning arrangements—WEDS in Wales—used to make use of that, but it's been discontinued, and I'm not sure now what has replaced it. But that's a different scene in England to what it is in Wales.

[17] Now, the one that we really liked was Scotland. I went up there and spent quite a bit of time with them. They took us through the way that they do things. The interesting thing about Scotland is that they don't look at other people. They decide what Scotland needs and do it. This kind of arrangement, which we suggested in the report, is what actually works in Scotland and works very well. They've reduced the deaneries from four to one; they've got integrated operations. It's taken time, and it's been difficult. They are aware of the difference between the rural needs and the urban needs and, in fact, the different urban needs; Edinburgh and Glasgow are very, very different. They have the confidence of the delivering bodies—the health boards and so on—and the confidence of the Government, which is also vitally important. So, broadly, that's the model we've gone for here—not altogether, because they don't actually do the workforce planning through the Scottish body; that's done separately. But, other than that, the functions are quite similar.

[18] **Caroline Jones**: Thank you very much.

[19] **Julie Morgan**: Can I just ask on that?

[20] **Dai Lloyd**: Julie.

[21] **Julie Morgan**: How long ago did the Scottish model start working; and have we got any results that have been researched and quantified?

09:45

[22] **Professor Williams**: Don't take my word for this, but I think it is something like—is it 10 years? It's that kind of scale. And, yes, there is evidence now that, for example, they've been able to do major changes in the area of dentistry—again, don't ask me for the details, my memory isn't that good—and also I understand that they are training more doctors now in Scotland than they need, which is a change in the situation from when they started. But everybody I talked to said they had confidence that this body was doing a really good job.

[23] **Julie Morgan**: Thank you.

[24] **Dai Lloyd**: Ymhellach at hynny, cyn inni symud ymlaen, a allaf i ofyn: mae yna rai pobl wedi dweud wrthym

Dai Lloyd: Further to that, before we move on, can I ask: some people have told us there are weaknesses in

ni fod yna wendidau yn y ffordd y mae'r ddeoniaeth, y Wales Deanery, yn gweithio ar hyn o bryd yn nhermau bod Cymru'n cael ei chyfrif fel un lle mawr ac wedyn bod anhawster denu meddygon ifanc yn ôl i mewn i Gymru, yn enwedig pan maen nhw'n gyplau sydd wedi priodi ac ati, rhag ofn bod un yn diweddu lan ym Mangor—gyda phob parch—a'r llall yn Nghaerdydd—eto gyda phob parch. Wrth gwrs, y system flaenorol oedd eich bod yn gallu gwarantu y buasai'r ddau efo'i gilydd yng Nghaerdydd, neu o leiaf yn y de, neu'r ddau efo'i gilydd yn y gogledd ac ati. A ydy pethau fel yna yn mynd i ddod i mewn i strwythur y corff newydd yma, fel eich bod chi'n gallu gwarantu bod newidiadau fel yna'n gallu cymryd lle?

the way the Wales Deanery works at the moment in terms of Wales being counted as one big location and then there's a difficulty in attracting young doctors back to Wales, especially when they maybe have married in the meantime, or something, in case they end up with one in Bangor and one Cardiff, which, with all respect, wouldn't be very workable. In the previous system, you could guarantee that the two could be together in Cardiff or in south Wales, or in north Wales, for example. Are things like that going to come within the structure of the new body, so that you can guarantee that those changes can happen?

[25] **Yr Athro Williams**: Yn sicr. Rydw i wedi clywed hynny dro ar ôl tro am y ddeoniaeth. Mae ganddyn nhw swydd anodd, anodd iawn i'w wneud, oherwydd ar yr un llaw mae cyrff iechyd eisiau gweithwyr ac, ar y llaw arall, mae angen rhoi'r addysg iawn i'r myfyrwyr. Ond, yn union, rwy'n meddwl bod yna gyfle i fod yn llawer mwy *innovative*—nid wy'n gwybod beth ydy'r gair Cymraeg—ac edrych ar ddulliau eraill o sut i ddelio gyda'r broblem yna.

Professor Williams: Certainly. I've heard that time after time about the deanery. They have a very difficult job to do, because on the one hand, there are the health bodies who need workers and then, on the other, there is a need to provide the right education for students. But, exactly, I think there's an opportunity to be much more innovative—I don't know the Welsh word—and look at other methods of how to deal with that problem.

[26] **Dai Lloyd**: Bendigedig. Dawn.

Dai Lloyd: Excellent. Dawn.

[27] **Dawn Bowden**: Thank you, Chair. Again, I was really interested to hear your comments about the strategic education and delivery group. I used to be a member of SEDG, and you're absolutely spot on, in terms of the

competitive nature of that organisation, between different organisations representing different professions. And I think one of the things that you alluded to was the that there was very much a vying process and a competition between the different professions for how many training places they would get for each—

[28] **Professor Williams**: And the hierarchy.

[29] **Dawn Bowden**: And the hierarchy. And so there was a lot of tension between the medical commissioning arrangements and the allied professionals and support staff commissioning arrangements. Now, under your proposals, you're going to be bringing these two bodies together. How do you think you—? What do you think are going to be the key challenges in overcoming not only the competition between the different professions, but between the medics and everybody else?

[30] **Professor Williams**: It's vital. I think you're absolutely right about these issues, so that's why it's so important to bring them together. But just to bring two groups together and let them operate as they are now, you might as well not bother. It's got to be a proper integration, and there's got to be a rethinking of the roles. Now, putting them together in one building is absolutely crucial, and what they told us in Scotland was: have an open plan place, where they have to have cups of coffee together. A lot of it is to do with that. Now, that's where the chair and the chief executive of this are so vitally important, because if you get that right at the beginning—and it will be a challenge and will take some time—I think it'll work, but if you're moving towards more inter-profession working, which I think is what's inevitably going to happen, then those barriers really need to be, not broken down, but bridged for them to be effective.

[31] **Dawn Bowden**: So, have you got any thoughts about—following on from that, really—about how this new body really is going to engage with all of the—? How can they successfully engage with the stakeholders, really?

[32] **Professor Williams**: It's crucial that the chief executive of this body sits with the other chief executives of the health boards in Wales, so that the workforce issues and commissioning and training is there right from the beginning, so that the chief executive can listen to the needs of the health board, the way they're thinking for the future, and can respond early. The same for the chairman—I think he needs to be around the same table as the chairs of the health authorities.

[33] So, the interface between this board and the health authorities is crucial, and needs to be well defined. We were told that very clearly in Scotland and in England, so that would be one of the first challenges. Then the body needs to work with, again, the education providers. I suggested here that when they hold meetings, they go around—we do that with the higher education funding council and it work very well—to listen to what people's needs are, both from the health boards and from the educational providers, for example Bangor in north Wales and Glyndŵr. Then there's a need to interact with all the royal colleges and the regulators and so on, and that's something that will have to be done, I guess, on a one-to-one basis.

[34] **Dawn Bowden**: Interesting.

[35] **Professor Williams**: Yes, it's a challenge.

[36] **Dawn Bowden**: Okay, thank you, Chair.

[37] **Dai Lloyd**: Julie.

[38] **Julie Morgan**: Just following that up, from what you've said, the relationship between the different bodies seems to be absolutely key, whether that's from an open-plan office to the structures that you're proposing. Do you think anything more is needed in order to make that working together happen?

[39] **Professor Williams**: It's difficult for me to say, but it will be the duty of the body itself to look at those issues. If they're able to appoint the right people, I'm sure they will look at how things are operating elsewhere and what are the key things that need to be introduced in order to ensure that. I'm sure they would want to look at the Scottish system, and they'd want to look at the successful local area boards in England, for example. I'd be a bit out of my depth if I were to go into that too seriously.

[40] **Julie Morgan**: So, you saw your role as the structure, setting it up—

[41] **Professor Williams**: I think the structure would be right in order to come up with the solutions.

[42] **Julie Morgan**: Thank you.

[43] **Dai Lloyd**: Dawn, did you want to come back now?

[44] **Dawn Bowden**: Yes, thank you, Chair. You may not be able to answer this, actually, just because, as you say, this wasn't really your remit, but I'm just wondering how you would see the role of the new body in developing workforce planning, which is going to be crucial to what we eventually end up with. What do you see the role of the new body in that?

[45] **Professor Williams**: I think the workforce planning needs to be well defined to start with. If you're going on an exercise of finding out what is needed, you must define, at the beginning, what it is that you need. Then you need to be able to interrogate the output of that. The workforce planning that's done now—. WEDS produced an excellent document—they do it very well—but, as far as I can see, there's nobody really questioning that and analysing it. What can you really learn from it that will translate into commissioning? The new body has got to get on top of that. My suggestion would be—but it would be for them—that they would probably have a sub-group that addresses workforce planning issues, and they may wish to bring in some experts. For example, there are experts in Whitehall who would be delighted to help, who have been through the middle of that. There are some very good experts in our universities in Wales. It would be for the new body to decide how they do things, but that would be one of the ways that they could function. I would suspect that the body will have different sub-groups: workforce planning, perhaps; education commissioning, perhaps; et cetera.

[46] **Dawn Bowden**: Okay, that's fine. Thank you.

[47] **Dai Lloyd**: Dal ar gynllunio'r gweithlu, mae cwestiwn gyda Caroline Jones—cwestiwn 10.

Dai Lloyd: Still on the topic of workforce planning, Caroline has a question—question 10.

[48] **Caroline Jones**: Diolch, Chair. Regarding workforce planning again, could you tell me: are you confident that the information and skills were available to support the workforce planning work, and are there gaps that need to be addressed, and what are the gaps?

[49] **Professor Williams**: I'm confident that the structure could be put together with the right expertise, whether it would be on the board itself or a sub-committee. They would be expert to a certain degree, but it may be that they need to look at who the best people are to advise in order to do this, and how you get the information and what substructures you need for that.

[50] **Caroline Jones:** Okay, thank you.

[51] **Dai Lloyd:** Mae'r cwestiwn nesaf o dan law Julie Morgan— cwestiwn 11. **Dai Lloyd:** The next question is from Julie Morgan—question 11.

[52] **Julie Morgan:** Thank you very much. Could you talk some more about how you think the new body will impact on the deanery?

[53] **Professor Williams:** As I said, the deanery has a very difficult job to do, and I saw some of the challenges they had when I talked to them. And there are a lot of things they do very well. But you probably know that the deanery is actually part of Cardiff University. There's nothing wrong with that—Cardiff has been a very good host for them—but I think it's the only one left in the UK that's not in the NHS. And if things went awry, who actually carries the can? And it is the chairman of the council, I guess, of Cardiff University, and the chief executive. Now, it should be in the NHS, I would think.

[54] And then, in the deanery, whether they could be more innovative by being part of a body that involves more professions and so on—maybe it's not for me to say, but that's the feeling I had when I was—

[55] **Julie Morgan:** But its focus was too narrow in terms of the professions.

[56] **Professor Williams:** Yes. I think what they do, they do very well, but there's a lot more, I think, that could be done by a larger body of the kind that I mention here. My feeling is that if they co-located and if they're talking all the time—if the communication within is good—that that will come because they're excellent people and they're doing their very best. The General Medical Council have great faith in them. So, that's what I think—co-location, I think, will lead to a lot of the kind of things that you might be looking for.

[57] **Julie Morgan:** Yes, and, obviously, there's a huge range of medical specialties—primary care all the different types of medical specialties—and, of course, there's community care, which is so important. So, we really need all those areas to have at least equal consideration, as well as the hospital care. So, what are your comments about that?

[58] **Professor Williams:** My thinking is that's exactly why I'm proposing

this body be a body of experts, so they can talk—

[59] **Julie Morgan:** Will it include people who are expert in all those fields?

[60] **Professor Williams:** No, but they will include people who understand what is required in those fields and who to go and talk to—you know, where to get advice from.

[61] **Julie Morgan:** So, is that linking back to what you said in the beginning that you didn't want people who were professionals from the field because that would mean they would fight their own corner?

[62] **Professor Williams:** Not in silos, but you do want people who have an awareness, I think, of—. But, you know, this is peer interaction. You really need experts to talk to experts. It's very difficult for, I guess, people like us to question the experts when they are giving advice, whereas other impartial experts can do that very effectively. So, I think that's a way. And also, in terms of looking more broadly at the deanery's involvement, the body would be in a good position to do that, if you can get the right people.

[63] **Julie Morgan:** You've said quite a lot about the right people in the right places, and I think that's—.

[64] **Professor Williams:** Absolutely, yes.

[65] **Julie Morgan:** Then, the other issue I wanted to cover was trying to reach out to Welsh schools and to make pupils aware of the opportunities that there are, and to try to sell the professions that there are. Have you got any views on that?

10:00

[66] **Professor Williams:** I'd better answer in terms of the report I've written, rather than in terms of my personal views.

[67] **Julie Morgan:** Yes. What can the new body do?

[68] **Professor Williams:** It can look at those issues.

[69] **Julie Morgan:** And would you see it as something that it should look at?

[70] **Professor Williams:** Absolutely. It's got to look at the pipeline, I think, of health-related people coming through, right from the schools. And there's a lot that can be done at that level—at every level, in fact. I would have thought that would be one of the tasks of the new body.

[71] **Julie Morgan:** Because one of my impressions from the schools when I go round is that many people don't aspire to the medical profession and some people see it as something that's not for them, or it requires too much academic knowledge. So, I think there are quite a lot of barriers and a lot of work to be done in that area. So, would you see this body as having this as one of the priorities?

[72] **Professor Williams:** Absolutely. Particularly so in rural areas, I suspect. I've seen some figures from the Welsh schools, which, you know—there's quite a bit that can be done there. But, I think this would be a very important part of the work. It's interesting that Scotland seem to be producing the numbers they need, if not more.

[73] **Julie Morgan:** And are Scotland producing the home-grown numbers?

[74] **Professor Williams:** That's right. Yes, largely. So, yes, a lot to be done. And then there's issues of retention and all that, which you are so familiar with, which I couldn't comment on. But the new body, I hope, would be in a position to do that, because I'm sure one of the tasks it would be given would be how do you increase the numbers, how do you encourage retention and all the rest of it.

[75] **Dai Lloyd:** Ar y pwynt yna, cyn symud ymlaen, Julie, mae gan Rhun gwestiwn.

Dai Lloyd: On that point, before you move on, Julie, Rhun has a question.

[76] **Rhun ap Iorwerth:** Jest eisiau rhoi senario bach ichi oeddwn i, a meddwl sut fyddai ymyrraeth y corff newydd yma yn dylanwadu ar y senario yma. Senario sydd wedi cael ei dynnu i'm sylw yr wythnos yma ydi o. Mae'n stori rwyf wedi'i chlywed llawer iawn yn rhy aml: bachgen 17 oed o Gaernarfon, canlyniadau TGAU

Rhun ap Iorwerth: I just wanted to put a scenario to you, if I may, and think about how the intervention of the new body would influence this scenario. It's something that's been brought to my attention this week, and it's a story that I've heard very many times: a 17-year-old boy from Caernarfon, fantastic GCSE results,

rhagorol, rhagolygon ei fod o'n mynd i gael lefel A ardderchog, yn gwneud cais i goleg meddygol Caerdydd i fynd yn feddyg—mae o eisiau gweithio yn y Gymru Gymraeg fel meddyg—mae o'n cael llythyr yn dweud nad ydy o'n cael cyfweliad. Beth fyddai'r dylanwad gan y corff newydd yma i drio atal y math yna o sefyllfa?

his predicted grades for A levels were excellent, made an application to the medical school in Cardiff—wanting to be a doctor and wanting to work in Wales through the medium of Welsh—and had a letter to say he's not having an interview. What sort of influence, now, could we have under this new body to try and stop this kind of situation?

[77] **Yr Athro Williams**: Rwy'n mawr obeithio y byddai'r corff yma yn edrych ar yr holl agweddau yna. Ar hyn o bryd, mae'n ddigon posib bod nifer o fyfyrwyr israddedig sy'n dod i mewn i Gymru—mai'r peth sydd fwyaf pwysig iddynt ydy *league tables* y Russell Group. I mi, nid yw hynny'n iawn, ond barn bersonol ydy hynny, ac mi ddylai'r corff yma edrych arno: os ydych chi eisiau meddygon i ardaloedd gwledig, pa fath o bobl sydd eu hangen? Nid lefelau A a TGAU, o reidrwydd, yw'r peth mwyaf pwysig. Dyna'n union y math o beth rwy'n meddwl y dylai'r corff edrych arno. Sut y byddai o'n gallu gwneud gwahaniaeth? Wel, os oes ganddyn nhw'r arian comisiynu, mae'n bosib gwneud drwy hynny, achos mae'n bosib cadw rhan o'r arian i wneud pethau newydd, er enghraifft.

Professor Williams: I really hope that this body would look at all of those aspects. At the moment, it's quite possible that the number of undergraduate students coming into Wales—that the most important things for them are the league tables of the Russell Group. To me, that's not right, but that's a personal view, and this body should look at it: if you want doctors for rural areas, what sort of people are required? The A levels and GCSEs aren't necessarily the most important issue, and this is exactly the sort of thing that the body should be looking at. How could it make a difference? Well, if they have the funding for commissioning, it's possible to do so through that. Because it's possible to keep part of that funding to do new things, for example.

[78] **Rhun ap Iorwerth**: Y sefyllfa ddelfrydol fyddai pe bai pob person yng Nghymru sydd eisiau astudio meddygaeth yng Nghymru yn gallu gwneud hynny, neu o leiaf yn cael y cyfle.

Rhun ap Iorwerth: Well, an ideal situation, of course, would be that every person in Wales who wishes to study medicine in Wales can do so, or at least have the opportunity to.

[79] **Yr Athro Williams**: Ac nid yn unig yn israddedig, ond *post-grad.* Mae yna nifer o rai ardderchog o Gymru a fyddai'n gallu dod yn ôl a dechrau cyrsiau byrrach, efallai, ac a fyddai'n gallu gweithio dros Gymru ac yn y gorllewin gwledig.

Professor Williams: And not only on undergraduate level, but also post-grad. There are a number of excellent students from Wales who could return and do shorter courses, perhaps, and would be able to work all over Wales, including west Wales.

[80] **Rhun ap Iorwerth**: Fy nghasgliad i—ac mae'n ymddangos bod eich casgliad chi'r un fath—ydy bod y system addysg feddygol yng Nghymru wedi anghofio, rywsut, mai ei phrif ddiben ydy darparu ar gyfer gweithlu'r NHS yng Nghymru mewn blynyddoedd i ddod.

Rhun ap Iorwerth: My conclusion—and I think yours is perhaps the same—is that the medical education system in Wales has forgotten, somehow, that maybe its main purpose is to provide the NHS workforce in Wales in the future.

[81] **Yr Athro Williams**: Fe wna i ddim rhoi *comment*, ond dyna y byddai'r corff newydd yn gallu rhoi ystyriaeth iddo.

Professor Williams: I won't comment, but that is what a new body would be able to consider.

[82] **Dai Lloyd**: Julie, wyt ti am gario ymlaen ar y thema?

Dai Lloyd: Julie, are you going to carry on with this theme?

[83] **Julie Morgan**: That's the sort of area that I think it's very important to look at.

[84] **Professor Williams**: I couldn't agree more

[85] **Julie Morgan**: I won't say any more than that.

[86] **Dai Lloyd**: Mae'n bwysig dweud pethau felly, Julie.

Dai Lloyd: It's important to say that, Julie.

[87] **Julie Morgan**: I've had lots of examples similar to Rhun, where very high-qualified students have not been able to get into Cardiff medical school, and are extremely disappointed, and have also had these high grades, so it's very hard to understand. But I think the reason is that there are just far too many applying, and because it has got a very good reputation, and, as you said, because of the Russell Group—and that's what

people look at—it's vastly oversubscribed—and, obviously, from all over the UK and elsewhere. So, that's a very important issue. Is that something that you think should be looked at?

[88] **Professor Williams:** Absolutely. I was told as part of this review, by some people, that they prefer an all-graduate entry.

[89] **Julie Morgan:** All graduates.

[90] **Professor Williams:** Yes, that medical students come in as graduates and get trained.

[91] **Dai Lloyd:** Like in Swansea.

[92] **Professor Williams:** I wasn't going to say that, but—

[93] **Dai Lloyd:** That's all right, you didn't. I said it. [*Laughter.*]

[94] **Professor Williams:** Because they're mature and they know what they want to do. They've decided, and they are much more likely to stay. I think, if you look at the figures, that that may be right. So, I think this body would need to look at undergraduate versus graduate entry, how do those suit Wales, can you have schemes that bring people back, and how do you bring our Welsh kids back from over the border—all kinds of things, in my view, that can be done, and are a very important part of the duty.

[95] **Dai Lloyd:** Cyn inni symud ymlaen a mynd off y pwynt yma, wrth gwrs, efo ysgolion meddygol yr Alban, mae nhw'n llwyddo i gael dros 50 y cant o'u myfyrwyr nhw yn dod o'r Alban—pob un o'r pump neu chwech ysgol feddygol sydd gyda nhw. Un sydd gyda ni, wrth gwrs, yn israddedig, yn y fan hyn, ac un yn Abertawe. Ac, wrth gwrs, efo ysgol feddygol Caerdydd, fel mae pobl wedi dweud wrthyf, nid ydych yn cael pwyntiau ychwanegol yn y system gyfweld os ydych chi un ai yn dod o Gymru neu yn gallu siarad Cymraeg.

Dai Lloyd: Before we move on and go off this point, with the Scottish medical schools, they succeed in getting 50 per cent of their students from Scotland—all the five or six medical schools they have in Scotland. We only have one undergraduate in Cardiff, and one in Swansea. But with Cardiff medical school, as people have told me, you don't have any additional points in the interview system if you either come from Wales, or if you can speak Welsh. That skill isn't recognised, nor the fact that you come from Wales.

Hynny yw, nid yw'r sgìl yna ddim yn cael ei gydnabod, na'r ffaith eich bod chi'n dod o Gymru. Hynny yw, gallwch chi ddod o unrhyw le. Dyna pam, wrth gwrs, rwy'n credu bod canran y myfyrwyr meddygol rywle o dan 20 y cant a rhywbeth yn nes i 10 y cant yn ysgol feddygol Caerdydd, ac yn Abertawe y dyddiau hyn. Felly, byddwn yn licio ein gweld ni'n dynwared yr Alban, a dweud y gwir, mewn nifer o ffactorau. Ac, wrth gwrs, mae yna ffyrdd o gynyddu'r canran o fyfyrwyr o Gymru sy'n astudio meddygaeth, heb orfod tanseilio unrhyw safonau, achos mae nhw'n llwyddo i'w wneud yn yr Alban heb orfod delio efo'r ddadl yna. Nid wyf yn gwybod beth ydych chi'n teimlo am y math yna o beth.

You can come from anywhere. That's why, of course, I think the percentage of medical students is somewhere under 20 per cent, and closer to 10 per cent, in Cardiff medical school, and in Swansea these days. Therefore, I'd like to see us imitating Scotland in a number of factors, and there is a way of increasing the percentage of students from Wales who study medicine, without having to undermine any standards, because they succeed in doing so in Scotland without having to deal with that argument. I don't know how you feel about that.

[96] **Yr Athro Williams:** Rwy'n cydweld yn union â'r ddadl, a dyma un o'r pwyntiau a ddaeth i fyny yn y drafodaeth gyda'r gwahanol *royal colleges*, yn enwedig y BMA. Y teimlad yw nad y lefelau A sy'n cael pwyntiau uchel, o reidrwydd, yw'r pethau ddylai fod ar dop pob math arall o bethau, fel siarad Cymraeg a gallu gweithio mewn gwahanol rannau o Gymru.

Professor Williams: I do agree exactly with what you're saying, and this is one of the points that came up in the discussion with the royal colleges, especially the BMA. There is a feeling that the A-levels that have high points are not necessarily the issues that should be the overriding concern, and come above everything else such as being able to speak Welsh and to work in different areas of Wales.

[97] **Dai Lloyd:** Julie, sori, roeddwn i wedi amharu ar—

Dai Lloyd: Julie, sorry, I interrupted you—

[98] **Julie Morgan:** Just following on with this theme, I don't know whether it's anecdotal, but it does seem that a large number of medical students come from families where the parents have been in the medical schools. And I just wondered, in your investigations, whether you felt there was anything

operating that meant it was easier for somebody to get into the medical school who had a—

[99] **Professor Williams:** No. That wasn't part of the remit at all. It's the kind of thing the body should look at. Bearing in mind now that, if the Diamond review is implemented and the funding situation is going to change, the body will need to consider whether those changes can help the situation that we have in Wales.

[100] **Julie Morgan:** The other issue I wanted to ask you about was female recruitment, which I believe is—. Often, in medical schools, for example, going back to medical schools, there is a higher percentage, maybe, of women. I don't know if that's true.

[101] **Professor Williams:** That's right, it's quite high.

[102] **Julie Morgan:** But, in terms of some of the prestige jobs in the medical profession afterwards, they don't get them, and in GP practice, women are very often much more interested in having the salaried posts rather than taking on the partnership. Is this the sort of area that is important to look at?

[103] **Professor Williams:** Again, I'd better not comment on my personal views, but one thing that did come over very clearly is that—thankfully, there are more women, certainly, in the Cardiff medical school than men, and that's great to see—the pattern of work of young people is changing. A lot take time off to travel the world after graduating. A lot now share jobs because of it being more family friendly and so on. Those are issues that need to be looked at in detail because, if that's the case, then you need to train more. You might say that training more is going to cost a lot of money, but bear in mind that the Diamond review now changes that situation. Then, it comes back to things like SIFT, which I don't fully understand. But absolutely; that needs to be looked at. So, not only are the health needs changing, but the medical workforce also. I'm not sure it's as true of the health profession generally, but certainly in the medical profession it's changing.

[104] **Julie Morgan:** I also wondered, when you were doing this work—I don't know whether you were looking at the implications of the Brexit vote or whether this didn't bring that in. Is that something that this new body is going to have to look at—the implications?

[105] **Professor Williams:** It is, yes. The Brexit vote came after I finished this.

[106] **Julie Morgan:** Yes, I thought it might have.

[107] **Professor Williams:** However, I have seen figures—particularly through HEFCW, which is a very important body from this point of view—and there is an implication, certainly, that if we lose European students, then that could be detrimental. Although, the numbers that I saw were significantly less than the numbers of overseas students from outside Europe—those numbers are quite high. The numbers from Europe, I think, are substantially less, but will have an effect and will need to be considered.

[108] **Julie Morgan:** I think they said today they were down 7 per cent overall—students from Europe. There was something on the news today.

[109] **Professor Williams:** I saw some figures for the home students today, but I hadn't realised that the European ones were down that much.

[110] **Julie Morgan:** I think so. You mentioned HEFCW. Could you say some more about HEFCW and how its role will operate and how it will work with the new body in the future?

[111] **Professor Williams:** It's very interesting, the new body, and it's one I personally fully approve of. In fact, HEFCW also put forward that there should be a body of that kind. The further education and higher education interface is a very interesting one. It's blurring. It's vitally important from the health point of view, because one of the things I'm sure you are giving a lot of thought to is social care—the caring side. I didn't touch on that because that's handled largely through the local authority and FE, but I think the new body that's been proposed to replace HEFCW could have a key role to play. It will need to work, therefore, very closely with the body that I'm proposing. I think there are great opportunities for trying to rationalise and make bridging that boundary more effective.

10:15

[112] **Julie Morgan:** Thank you.

[113] **Dai Lloyd:** Dim ond i bwysleisio cyn inni orffen beth oedd Julie wedi'i ofyn ynglŷn ag ysgolion,

Dai Lloyd: Just to emphasise, before we finish, what Julie has asked about schools, and Rhun also, and of

a Rhun hefyd, ac, wrth gwrs, yr angen i gydweithio neu i annog ein hysgolion ni yng Nghymru i feddwl am iechyd yn y lle cyntaf ac i feddwl am feddygaeth a nyrsio yn lle jest gadael y peth i fyny i deuluoedd unigol felly. A hefyd, mae angen rhyw fath o hyfforddiant o ran cyfweliadau meddygol achos pan mae'n dod i'r 'crunch', mae ein pobl ifanc talentog ni weithiau ddim yn gallu sgleinio cweit yn ddigon hyderus yn y fath amgylchiadau. Nid mater o a ydy eich rhieni chi'n feddygon ydy'r peth, ond y ffaith, os ydych chi'n teimlo'n hyderus eich bod chi'n mynd i fod yn llwyddiant fel person ac fel meddyg.

course the need to collaborate or to encourage our schools in Wales to think about health in the first place and to think about medicine and nursing rather than just leaving it to individual families. And also, we need some kind of training in terms of medical interviews because when it comes to the crunch, our talented, young people sometimes can't shine and are not confident enough in such situations. It doesn't matter if your parents are doctors or not; you need to feel confident in yourself as a person and to feel that you could succeed as a doctor.

[114] Mae ysgolion bonedd Lloegr yn gallu gwneud hyn a dyna beth maen nhw'n treulio eu holl amser yn ei wneud, rwy'n credu, ond mae yna le, buaswn i'n meddwl, i'n hysgolion uwchradd fod yn rhan o hyn, neu o leiaf fod rhywun yn cyfeirio atyn nhw a bod yna rhyw fath o strwythur. Buaswn i efallai'n meddwl bod y corff newydd yma mewn lle arbennig i alluogi hyn ac o leiaf i bobl ddechrau meddwl am y peth, achos mae'n rhaid derbyn yr hyfforddiant yna y mae pobl ifanc eraill yr ynysoedd hyn yn ei dderbyn er mwyn gallu disgleirio yn y cyfweliadau meddygol yma.

Private schools in England can do this, and I think they spend all of their time doing it, to be honest, but I think there's perhaps scope here for our secondary schools to do something like this, or at least that somebody can work with them on it to have some sort of structure. Maybe this new body would be in a very good place to do this, so that people can start thinking about it, because having that coaching that other young people in these islands have in order to shine in these medical interviews is very important.

[115] **Yr Athro Williams**: Mae hynny'n hollol wir ac rwy'n meddwl y gall y corff yma wneud gwahaniaeth cyn belled ag y mae hynny'n y cwestiwn. Mae'n ddigon posibl y

Professor Williams: That is absolutely true and I think this body could make a difference as far as that is concerned. It's quite possible that the committees under the board

byddai'r pwyllgorau o dan y bwrdd yma yn gallu delio gyda'r math hwnnw o broblemau.

could deal with those kinds of issues.

[116] **Dai Lloyd**: Grêt, bendigedig. Rwy'n credu ein bod ni ar ben â chwestiynau oddi wrth fy nghyd-Aelodau. A allaf i ddiolch yn fawr iawn i chi, Robin, am eich ymddangosiad a hefyd am yr holl waith clodwiw sydd wedi mynd gerbron i baratoi'r ffordd, achos rydym ni wedi bod yn meddwl am yr adolygiad yma ers cryn dipyn o amser? Roedd yna bryder o sawl ochr ynglŷn â sut oedd pethau'n gweithio neu ddim yn gweithio, ac yn enwedig rôl y ddeoniaeth. Felly, rydym ni'n falch i gydnabod bod yna ffordd amlwg ymlaen yn fan hyn. Felly, diolch yn fawr iawn i chi am eich gwaith caled iawn yn y maes yna a hefyd am eich ymddangosiad y bore yma ac am ateb yr holl gwestiynau mewn ffordd mor raenus ac aeddfed. Diolch yn fawr iawn i chi.

Dai Lloyd: Great, excellent. I think we've come to the end with regard to our questions from fellow Members. Can I thank you very much, Robin, for your appearance today and for all the excellent work that has been done in order to prepare the way here, because we've been thinking about this review for some time? There was some concern from several quarters about how things were working or not working, especially the role of the deanery. So, we are very happy to see that there is a clear way forward here. So, thank you very much for your very hard work in this area and also for your appearance today and for answering all our questions in such a polished and mature manner. Thank you very much.

[117] **Yr Athro Williams**: Diolch i chi a phob hwyl gyda'r gwaith. Mae'n amserol dros ben.

Professor Williams: Thank you and good luck with all the work. It is extremely timely.

[118] **Dai Lloyd**: Diolch yn fawr. Fe wnawn ni dorri am egwyl breifat rŵan, gyda'ch caniatâd.

Dai Lloyd: Thank you very much. We will have a private break now, with your permission.

Gohiriwyd y cyfarfod rhwng 10:18 a 10:47.
The meeting adjourned between 10:18 and 10:47.

Ymchwiliad i Recriwtio Meddygol—Sesiwn Dystiolaeth 2—Panel Hyfforddeion
Inquiry into Medical Recruitment—Evidence Session 2—Trainee Panel

[119] **Dai Lloyd:** Croeso i chi i gyd. A allaf i alw cyfarfod y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon i drefn am yr ail sesiwn y bore yma? Eitem 3 i'w nodi i fy nghyd-Aelodau ydy ein bod ni'n parhau efo'n hymchwiliad i recriwtio meddygol. Hon ydy'r ail sesiwn dystiolaeth, ac o'n blaenau ni mae panel hyfforddeion—pum meddyg ifanc, addawol yn amlwg. [*Chwerthin*.]

Dai Lloyd: Welcome to you all. Can I call the meeting of the Health, Social Care and Sport Committee to order, please, for the second session this morning? Item 3, to note to my fellow Members, is that we are continuing with our inquiry into medical recruitment. This is the second evidence session, and before us we have a trainee panel—five young doctors who are very promising, of course. [*Laughter*.]

[120] Nid oes angen poeni am ddim byd, yn naturiol, yn fan hyn. Mae gennym ni restr o gwestiynau i'w gofyn i chi dros yr awr nesaf. Nid oes yn rhaid ichi deimlo rheidrwydd fod yn rhaid i bob un ohonoch chi ateb pob cwestiwn, neu mi fyddwn ni yma tan yn hwyr yn y nos, ond, os oes rhywbeth wir yn llosgi ac rydych chi'n teimlo'n danbaid ynglŷn ag ef, ewch amdani. Ond, nid oes angen teimlo rheidrwydd i ateb pob un wan jac cwestiwn.

You don't have to worry about anything, of course. We do have a list of questions that we'd like to ask you over the next hour. You don't have to feel that every one of you has to answer every question or we will be here until late this evening, but, if there's anything that you feel very strongly about, please go for it. But you don't have to answer every single question.

[121] Felly, byddwn ni'n clywed eich safbwyntiau chi. Rŷm ni wedi clywed oddi wrth yr Athro Robin Williams eisoes. Yn naturiol, mewn sesiynau tystiolaeth eraill ar recriwtio meddygol, mi fyddwn ni'n clywed cyfraniadau gan arbenigwyr eraill yn y maes. Rŷm ni wedi derbyn un adroddiad yn fan hyn gan Dr Huw Lloyd Williams, a diolch yn fawr iddo

So, we're going to listen to your opinions. We've already heard from Professor Robin Williams. Of course, in other sessions on medical recruitment, we will be having contributions from other experts in the field. We have had one report from Dr Huw Lloyd Williams, and thank you very much for that. Can I welcome you all here: Dr Zahid Khan,

fe. A gaf i groesawu chi i gyd, felly: Dr Zahid Khan, Dr Huw Lloyd Williams, Dr Abby Parish, Dr Bethan Roberts a Dr Llion Davies? Fel yr wyf i wedi crybwyll eisoes, mae gan ein Haelodau ni restr o gwestiynau, felly mi awn ni'n syth mewn i'w gofyn nhw, gyda'ch caniatâd. Felly, a gawn ni ddechrau efo Caroline Jones?

Dr Huw Lloyd Williams, Dr Abby Parish, Dr Bethan Roberts and Dr Llion Davies? As I've already mentioned, our Members have a list of questions, so we will make a start on those, with your permission. Can we begin with Caroline Jones, please?

[122] **Caroline Jones:** Thank you, Chair. Good morning. I wonder whether I could ask what it was that made you want to train and work in Wales.

[123] **Dai Lloyd:** Nid oes eisiau ichi fod yn swil. Fe ddywedais i nad oes raid i bawb ateb, ond mae'n rhaid i rywun ateb. [*Chwerthin*.]

Dai Lloyd: Don't be shy. I said that not everyone has to answer, but somebody has to answer. [*Laughter*.]

[124] **Dr Parish:** I'll go first then. I'm from Bridgend—it didn't really enter my mind to leave Wales. It's not the best sort of answer, but that's where I'm from. I did apply to other universities, but I got into the one I wanted, which was Swansea.

[125] **Caroline Jones:** Thank you.

[126] **Dr Davies:** A ydw i'n gallu siarad Cymraeg?

Dr Davies: Is it okay for me to speak Welsh?

[127] **Dai Lloyd:** Wyt—caria di ymlaen.

Dai Lloyd: Yes, of course.

[128] **Dr Davies:** *Echo* i hynny, *really.* Rwy'n dod o Gymru ac roeddwn i am ddod yn ôl i fyw yng Nghaerdydd, felly dyna beth wnes i.

Dr Davies: I can just echo that. I'm from Wales and I wanted to come back to live in Cardiff, so that's what I decided to do.

[129] **Dai Lloyd:** Diolch yn fawr. Jayne, wyt ti eisiau cario ymlaen efo'r cwestiwn nesaf?

Dai Lloyd: Thank you. Jayne, do you want to carry on with the next question?

[130] **Jayne Bryant:** Brilliant, thank you. So, what was your initial

undergraduate medical education training in Wales like? Two of you have said that you're from Wales—what about the rest of you?

[131] **Dr Roberts:** I can't actually answer that question because I trained in England, so—[*Inaudible.*]

[132] **Jayne Bryant:** Okay. [*Laughter.*]

[133] **Dr Roberts:** Because Cardiff wouldn't have me.

[134] **Jayne Bryant:** Ah, yes.

[135] **Angela Burns:** That's interesting.

[136] **Dr Roberts:** Just to get that in there.

[137] **Dr Parish:** Cardiff didn't let me in either. I applied to the Swansea graduate medicine programme, and I applied to Cardiff undergraduate. Swansea let me in; Cardiff didn't. So, after my first two years in Swansea, I joined the fourth year at Cardiff. I just thought that it was quite funny that they wouldn't let me in.

[138] **Dai Lloyd:** I think Angela's got a burning issue.

[139] **Angela Burns:** It's just very interesting that you say that because I've had a very bright constituent come to me, with exactly the same thing—he went to one of these fairs and Cardiff said, 'Don't even bother', and he's just going to Cambridge now. That's such a shame because we're losing our talent, and it does seem to centre around the Cardiff medical school. So, I'd quite like us to bottom that out because we don't want to lose people. We want to try and encourage as many people into Wales, and I think people do tend to stick where they train.

[140] **Dr Roberts:** Yes.

[141] **Dr Parish:** Yes.

[142] **Dr Williams:** They definitely do. On my experience at Cardiff medical school, I started there in 2003. I think the course has changed an awful lot since then. There's a new C21 curriculum, which I'm sure you're aware of. I think that's probably changed for the better. It was very good back then,

from my experience, anyway. So, I think it's definitely going in the right direction.

[143] **Dai Lloyd:** Anybody else's experience? Dr Khan?

[144] **Dr Khan:** I haven't trained over here. Basically, I'm from Afghanistan, so I can't basically comment on the undergraduate training, but, before coming to Wales, I worked in England for about 18 months. The main reason for coming to Wales for training was that I had heard from a colleague, basically, that the Wales training is a bit more supportive in terms of training than England and Scotland. That was the main reason for which I came over here, to Wales.

[145] **Dai Lloyd:** Okay. Caroline, do you want to press on with the same sort of theme?

[146] **Caroline Jones:** If you like. What, do you think, are the most important factors that influence where you train and where you work, and what you want to get out of the place where you train and work?

[147] **Dr Davies:** I think the factors change as you change with age. So, the factors are important. In your 20s, you know, you can work long hours, and it doesn't matter that you're not going to be home on time, if you haven't got children to pick up. It's very different to when you hit your mid 30s, when you do have to do those things. So, for me, I graduated in 2004 from Cardiff. It's hugely changed in that time. I think that working somewhere where you are in a supported environment is probably the most important thing—and career prospects.

[148] **Caroline Jones:** Yes.

[149] **Dai Lloyd:** A oes unrhyw un arall eisiau dweud rhywbeth?

Dai Lloyd: Would anyone else like to add something?

[150] **Dr Roberts:** Well, I think, if you're from Wales, you kind of have an idea of what things are like, but I think the big issue for us—. I'm the Chair of the Wales Junior Doctors Committee with the British Medical Association, and it's the perception that, for people who are not from Wales, that was a big deal. People don't quite understand how things work here, or they don't want to understand. There's a perception that things aren't quite as good here. It's actually the perception that's the battle, not the reality.

[151] **Dr Parish**: One of my colleagues is from Cardiff. She's a Welsh speaker. She went to an English medical school, and she did her—. When you finish medical school, you do your F1 and F2, as I'm sure you know—the foundation year programme—and then you start applying for some specialities. So, she did her first two years as a doctor—the F1 and F2—I think, in London and she actively chose to come home for her paediatric training, to become a paediatrician. When she told people that she was coming back to Wales, people had the attitude of, 'Oh, didn't you get in to London?' That's what they were saying to her. They genuinely felt sorry for her even though it was her, actively—. I obviously think that the training here is great, but that attitude isn't across the border.

[152] **Caroline Jones**: It isn't. That's unfortunate, because the training is of a high spec in Cardiff.

[153] **Dr Williams**: I'm not too sure whether you can take training as an issue that brings people here or keeps people here. You've got to look at a different speciality at a time. I think training from one speciality to another can be extremely different, and the experience that you get. And the reputation that comes from that can be very different too.

[154] **Dr Parish**: Elin is a Welsh speaker, but a lot of people said things to her, like, 'Oh, I can't go and work in Wales; I don't speak Welsh'. Some people think you need to speak Welsh. It's clearly an advantage, but I don't speak Welsh. As a country, I think people are almost discounting ways, even though the training is good and people might come. She had a lot of people actively saying things to her, like, 'Oh, I can't go there; I don't speak Welsh. I wouldn't be able to do it'. It's sad. It's a really sad attitude.

[155] **Dr Williams**: There's a misunderstanding.

[156] **Dr Parish**: Yes, but maybe people don't want to look for the information and clarify anything. They just think, 'Okay, fine; there are 16 other deaneries. I'll look at those'.

[157] **Dr Khan**: I think these points and then beside that—. You are definitely looking for the working environment, like what sort of environment you are working in. Then, definitely, another factor is lifestyle—the work-life balance. You are definitely looking for work, but you want some social life as well at the same point. Another important thing that I have noticed is, for example,

if you work in a certain hospital and set-up, you want to look at the amount of paperwork and the computer software that they use. Some of them can be really demanding and they really waste a lot of time, but others are quite feasible and they make life easy for you.

[158] **Caroline Jones**: You said you did 18 months in London, didn't you?

[159] **Dr Khan**: I was in Peterborough.

[160] **Caroline Jones**: Right. So, how does the London environment compare with Wales then, if I may ask?

[161] **Dr Khan**: If I talk about working environments: I think it's a bit more social and more interactive in Wales compared to Peterborough. There, even on the same ward, we didn't know each other. Although we were colleagues, we didn't know each other, but here, everybody knows each other. Even if they're not in our department, we know each other. Regarding IT, I think the software in England is a bit more sophisticated and a bit more supportive than the one we use in Wales. A lot of things in England, in Peterborough, we used to do online, but here we have to fill in paperwork and then we send it. Sometimes it goes missing and then things get difficult for the patient and we have to struggle to get things sorted.

[162] **Caroline Jones**: Thank you.

[163] **Dai Lloyd**: Rhun, roedd gennyt ti gwestiwn atodol.

Dai Lloyd: Rhun, you had another question.

[164] **Rhun ap Iorwerth**: Yn dilyn i fyny ar beth ddywedoch chi, Bethan—rydym yn ddiolchgar iawn eich bod chi wedi dod yn ôl i Gymru, yn amlwg—pwy wnaeth ofyn i chi ddod yn ôl? Pwy wnaeth eich tracio chi i lawr a dweud, '*Come on*, Bethan, rwy'n gwybod eich bod chi wedi methu â chael i mewn i'r coleg yng Nghaerdydd, ond rydym eich angen chi yn ôl yn yr NHS, felly dyma pam ddylech chi ddod yn ôl'? Rwy'n 'guess-io' beth ydy'r ateb.

Rhun ap Iorwerth: Following on from what you said, Bethan—we're very grateful that you have come back to Wales, clearly—who asked you to come back? Who tracked you down and said, 'Come on, Bethan, I know you didn't get into the college in Cardiff, but we need you back in the NHS, so this is why you should come back'? I'm guessing the answer.

[165] **Dr Roberts**: Ni wnaeth neb ofyn i mi ddod yn ôl.

Dr Roberts: Nobody asked me to come back.

[166] **Rhun ap Iorwerth**: Diolch yn fawr.

Rhun ap Iorwerth: Thank you.

[167] **Dr Roberts**: Gwnes i raddio yn 2004 ac aros yn Llundain am bum mlynedd cyn dod yn ôl. Gwnes i *psychiatry training* yn Llundain a dyna pam rwy'n ffaelu cymharu gweithio yng Nghymru a gweithio yn Lloegr achos mae'r *training programmes* mor wahanol. Nid oes cymhariaeth. Gwnes i fynd am swydd yn Llundain a chefais gyfweliad ond chefais i mo'r swydd. Roeddwn yn gwybod na fyddai swyddi ar ôl ar gyfer yr ail rownd yn Llundain, so dyna pam des i yn ôl. Gwnes i fynd am yr un swydd, *core medical training*, yng Nghymru.

Dr Roberts: I graduated in 2004 and stayed in London for five years before coming back. I did my psychiatry training in London and that's why I can't compare working in Wales with working in England because the training programmes are so different. There is no comparison. I went for a job in London and I had an interview, but I didn't get the post. I knew that there wouldn't be any jobs left in the second round in London, so that's why I came back. I went for the same job, core medical training, in Wales.

[168] **Rhun ap Iorwerth**: Pe byddech chi wedi cael y swydd, mi fyddech yn gweithio yn Llundain ar hyn o bryd. A oedd hi'n ddymuniad gennych chi, serch hynny, i ddod yn ôl i Gymru ac, eto, a oedd y cyfleon hynny'n cael eu dangos i chi ar unrhyw bwynt fel opsiwn i ddod yn ôl?

Rhun ap Iorwerth: If you had had that job, you'd be working in London at the moment. Did you want to come back to Wales, however, and, again, were those opportunities shown to you at any point as an option to come back?

[169] **Dr Roberts**: Na. Gwnes i fyth meddwl y byddwn i'n dod yn ôl, a dweud y gwir. Byddwn i'n dal i fod yno pe bawn i wedi cael y swydd, siŵr o fod.

Dr Roberts: No. I never thought that I would come back, to be honest. I would still be there if I'd had the job, probably.

[170] **Rhun ap Iorwerth**: Mae hyn yn allweddol: pam na fyddech chi wedi

Rhun ap Iorwerth: This is a key issue: why wouldn't you have come back,

dod yn ôl, o gofio mai fan hyn yn wreiddiol yr oeddech wedi bwriadu a gobeithio gallu gwneud eich hyfforddiant?

remembering that originally you had intended and hoped to train here?

[171] **Dr Roberts:** Roedd e jest achos fy mod wedi sefydlu yna, roedd ffrindiau gen i yna. Mae teulu gen i yng Nghaerfyrddin ac maen nhw'n bell i ffwrdd o Lundain, ond roeddwn i'n yn hapus yn byw yna, roedd digon yn mynd ymlaen ac roeddwn yn mwynhau gwaith. So, wnes i ddim 'really' meddwl am ddod yn ôl.

Dr Roberts: It was just because I was established there, I had friends there. I've got family in Carmarthen, so they're far from London, but I was happy living there, there was a lot going on and I enjoyed the work. So, I didn't really think about coming back.

[172] **Rhun ap Iorwerth:** I'r lleill ohonoch chi, faint ohonoch chi sy'n ymwybodol o fyfyrwyr sy'n dod o Gymru sydd wedi mynd i ffwrdd i gael hyfforddiant ac sydd un ai wedi dod yn ôl, a beth yw eu stori nhw, neu heb ddod yn ôl, a beth yw eu stori nhw?

Rhun ap Iorwerth: For the rest of you, how many of you are aware of students who come from Wales who have gone away to be trained and either have come back, and what is their story, or haven't come back, and what is their story?

[173] **Dr Davies:** Rwy'n adnabod llawer sydd wedi mynd dros y blynyddoedd. Gwnaeth llawer o bobl adael ar ôl y rhaglen *modernising medical careers*. Gwnaeth llawer ohonynt fynd i lefydd fel Awstralia, bryd hynny. Y peth yw, roeddent yng nghanol eu 20au. Nid oeddent yn mynd i benderfynu mynd am byth, ond wedyn roeddent yn cwrdd â phobl mas yna ac wedyn yn aros. So gwnaeth grŵp fyth dod yn ôl o fy *cohort* i. Wedyn, mae gen i lot o ffrindiau sydd wedi symud. Roedd tri ohonom yn y tŷ tra roeddem yn yr ysgol feddygaeth. Mae un nawr yn Oxford ac mae un ar y *south coast* ac

Dr Davies: I know many who have gone over the years. Many people left after the modernising medical careers programme. Many of them went to places such as Australia at that time. The thing is they were in their mid 20s. They weren't deciding to go forever, but then they were meeting people out there and then staying there. So, a group from my cohort never came back. Then, I have many friends who've moved. There were three of us in the house when we were in medical school. One is now in Oxford and another is on the south coast and they didn't come back. They moved and had work and

ni wnaethant ddod yn ôl. Fe wnaethant symud a chael gwaith ac yna y gwnaethant aros ac wedyn cwrdd â phobl ac aros.

stayed there and met people and stayed.

[174] **Dr Roberts:** A gaf i jest ddweud nid oedd lot o bobl—? Roedd tua phump neu chwe pherson o Gymru yn fy mlwyddyn i ac maen nhw i gyd wedi aros yn Llundain. Daeth un person yn ôl jest dros dro. Mae e wedi cael swydd ymgynghorydd yn Llundain nawr. Fi yw'r unig berson sydd wedi dod yn ôl.

Dr Roberts: Can I just say that there weren't many people—? There were about five or six people from Wales in my year and they've all stayed in London. One person came back temporarily. He has had a consultant's post in London now. I'm the only one who has come back.

[175] **Rhun ap Iorwerth:** Os ydych yn cofio yn ôl i'r flwyddyn gyntaf, faint o'r rheini oedd yn meddwl, yr adeg yna, y byddai'n dda mynd yn ôl a gweithio yng Nghymru, tybed?

Rhun ap Iorwerth: If you remember back to the first year, how many of those were thinking at that point that it would be good to come back and work in Wales?

[176] **Dr Roberts:** Nid wyf yn siŵr. Mae'n amser maith yn ôl.

Dr Roberts: I'm not sure about that. It's a long time ago.

[177] **Dai Lloyd:** Yn dilyn o hynny, mae gan Jayne gwestiwn olaf.

Dai Lloyd: Following on from that, Jayne has a question.

[178] **Jayne Bryant:** Do you think you're likely to stay in Wales and what would make you stay here? Abby's mentioned, you know, you didn't want to leave.

11:00

[179] **Dr Parish:** But I might have to. I'm a paediatrician, so I'm a registrar—I've been a paediatrician for a few years now. I want to subspecialise in neonatal medicine, and we go through an application process, which I'll be doing in September this year. It's a national programme. There are three jobs in Wales to specialise as a neonatologist each year, and I know at least five or six people who are applying for it. So then, if I don't get it and I want to continue my career, I'm going to have to move. Wherever you end up

moving, you then make your contacts; you settle in. If you get on with them then, I can see a lot of people—you basically want to stay where you are. If I move, then I've got two small children, they'll be coming with me, obviously—[*Laughter.*]

[180] **Jayne Bryant:** I'm glad you clarified that one.

[181] **Dr Parish:** So, I'll probably take them and maybe my husband, but he's going to have to change his job. He's not a medic, so he'll have to get a job somewhere else. They'll have to go to a different school. They're in a Welsh-speaking school, so they're going to struggle to go to an English school anyway—well, one's only two. So, I might not be able to stay here. I might have to leave to follow the career I want, and a lot of people I know who have left—. I'm on about paediatricians now. It's because when we subspecialise, a lot of the speciality jobs are either mixed with England or you have to go to England. This is a national process; I'm not going to have any choice. If other people are ranked higher and they want to come to Wales, then I'm not going to be able to stay.

[182] **Dr Williams:** I've got the exact opposite experience of that, I think, because in emergency medicine, we're a very small community—small in number in Wales and, actually, even though Wales has a large deanery, the numbers in emergency medicine training are quite small. There's a lot of flexibility within our training scheme, so we're able to ask for certain things and, normally, because there's that small number, they'll be able to be very flexible—bend over backwards, almost—to make sure you are able to do what you want to do. So, taking it out of programme training, et cetera, is something that's very achievable in emergency medicine, I would say.

[183] **Dr Parish:** It used to be like that with us. If you wanted to specialise in neonates—. As paediatricians, obviously, we can specialise in cardiology—there are lots of different things we can do. For neonatal, there are three tertiary neonatal units in south Wales, so there are more than an adequate—. They're very woefully understaffed, as most of the paediatric units are, so there are jobs for us. If I went, there'd still be gaps on every single rota, but, because of this new national programme for training, it's out of my hands. I won't be able to be a working neonatologist if I don't do the grid training, even though I could have exactly the same jobs if I stayed. But I wouldn't be able to get a job in a tertiary unit such as Cardiff, Swansea or Newport.

[184] **Dai Lloyd:** Angela.

[185] **Angela Burns**: Abby, could I just ask you: is the national programme what the royal college has put together?

[186] **Dr Parish**: Yes, it's the royal college national programme.

[187] **Angela Burns**: I just wanted to check. It's not a deanery-driven thing, it's a royal college—

[188] **Dr Parish**: No, it's the royal college.

[189] **Dai Lloyd**: Mwy ar hyfforddiant nawr. Dawn, rwyt ti'n arwain ar hyfforddiant ac wedyn cawn ni Julie.

Dai Lloyd: More on training now. Dawn, you are leading on training, and then we'll have Julie.

[190] **Dawn Bowden**: Yes, thank you. I just want to take you back to the initial questions about training and, really, about your experiences of training in Wales, and in particular the kind of level of support that you've received, either from senior colleagues or from the training bodies themselves. What's actually been your experience? So, your experience here and if you've got some comparative experiences with England as well, that would be helpful to know.

[191] **Dr Roberts**: I've worked in two specialties in Wales, so I did core medical training and then I switched to GP, and I think the way that the core medical training was set up at the time I was doing it wasn't very good. So, you had an odd collection of jobs that, maybe, didn't quite set you up to be the medical registrar who was often the most senior medical person in the hospital at night—

[192] **Dawn Bowden**: And where was this, sorry?

[193] **Dr Roberts**: It was all across south Wales. I worked at Neath Port Talbot, Bridgend, Royal Glam and UHW as well. So, I think that there needs to be a bit more thought about how jobs are put together and what you produce at the end of that core training, whereas my experience in GP training then has been the complete opposite. They took into account my previous experience, I didn't have to repeat any jobs that I'd done before and I got to do 18 months of hospital specialties that I'd never worked in before. There were very supportive seniors who wanted to know where we wanted to work, what we'd done before and planned our programmes in a fairly

bespoke way. And that was on the Gwent scheme. I think most schemes run in a fairly similar way.

[194] **Dawn Bowden**: Okay. At that stage you were working out of the Gwent area on that.

[195] **Dr Roberts**: Yes.

[196] **Dawn Bowden**: Anybody else?

[197] **Dr Davies**: I've worked in two specialties in Wales as well. I did general surgery for 10 years, and I was very well supported by people whom I consider to be mentors, and I still keep in touch with some of them now. And then I did make a career change, and there was a multifactorial reason behind that—I won't go into that, but I did make a career change—and I found the same again. I'm very well supported by, basically, the consultants.

[198] **Dawn Bowden**: Okay. Is that the general experience?

[199] **Dr Williams**: I think that the vast majority of the emergency medicine trainees in Wales find that they're very well supported by senior colleagues and also the bodies. I think there is one issue in emergency medicine with our north Wales trainees. There are quite a few north Wales trainees and their access to training is, perhaps, a bit more complicated than for us in south Wales. So, for instance, if they come for a training day down in south Wales, it normally would mean taking two study days to come down to do it. There's also the cost of coming down. Therefore, we don't tend to see our north Wales trainees as much on our training days.

[200] **Dawn Bowden**: Because that's not provided in the north?

[201] **Dr Williams**: There is some training provided in the north, but not as much. We get regular monthly training, where they don't. So they've had to go over to the Mersey deanery to have their training done there. I think that's one of the issues that our north Wales trainees are finding, but for south Wales—

[202] **Dawn Bowden**: It's okay in the south.

[203] **Dr Williams**: Yes, there's a bit of a difference there. I think that's probably the only issue within our speciality, in terms of training.

[204] **Dr Parish:** Our north Wales trainees go to Mersey for their study days as well. We've tried video-conferencing and other things, but it just doesn't work.

[205] **Dr Williams:** It doesn't work.

[206] **Dawn Bowden:** Not for something like that, no.

[207] **Dr Williams:** The other issue with their study is that the study budget that they have to be able to come down here is the same as what we get, but, for instance, they've got a lot more expenses to come down to south Wales. So, they spend a night down here, et cetera—

[208] **Dawn Bowden:** It eats into their budget much quicker.

[209] **Dr Williams:** Yes, absolutely.

[210] **Dr Khan:** I think that the level of support is more here, in a way, compared to England. It's definitely more supportive, and the senior staff especially are more supportive in terms of training and other issues in Wales than England. However, there are a few things, like, for example, the level of teaching or the sessions of teaching: I think there were a bit more in Peterborough in England, compared to Wales, but I think that varies from hospital to hospital. In the previous hospital I worked in in Wales, there was not much teaching for core medical trainees, but now I've moved to Prince Philip Hospital, the level of teaching is a bit more. So, we have regular sessions over there.

[211] And then the other issues that I've noticed is, for example, if I'm going for some training or if I'm doing an exam, if I need annual leave or study leave for that time period, it becomes a bit difficult to get it over here. And the reason being that, in England, I think, there are more trainees and there are a lot of non-trainee doctors in England, so they can adjust, somehow, the rota, but over here, if you want to take some leave, it becomes a bit difficult because they can't find someone to fill that rota.

[212] **Dawn Bowden:** To fill the gaps, yes. So, if I can—

[213] **Dr Roberts:** Sorry, can I just say—?

[214] **Dawn Bowden**: Yes, please.

[215] **Dr Roberts**: I wonder if it's slightly simplistic to be comparing England and Wales. I think it's very specialty dependent. Having done psychiatry in London, I was very well supported and it was a very well-organised scheme. So I think the problem isn't the comparison between Wales and England, I think it's the comparisons between specialities within Wales.

[216] **Dawn Bowden**: Sure, I understand. That's a good point. And I wasn't really trying to draw direct comparisons between England and Wales, what I was trying to establish from you is if you were satisfied that the level of training, the type of training and the support you get is adequate to do what you do, and I think you were saying, by and large, it is. So, if I can summarise then: the training per se doesn't seem to be a problem, but there does appear to be a problem from outside Wales with the perception of what they might get in Wales, and that is a bit of a barrier. Is that—?

[217] **Dr Roberts**: Sorry, just to disagree with that point, I did have an issue with my core medical training, because it was so badly put together. Because of rota gaps, I was doing the work of three people. So I was on my own, on a ward, as a senior house officer equivalent.

[218] **Dawn Bowden**: Which specialty was this?

[219] **Dr Roberts**: Well, the specialty itself was gastroenterology, but it was within a core medical training programme. And I couldn't even get off the ward to go and see my educational supervisor, go to teaching sessions, or anything. So I would say that training in some specialties isn't that good.

[220] **Dawn Bowden**: It depends what you—

[221] **Dr Roberts**: Yes, it depends what you do.

[222] **Dr Williams**: It also works the other way around. As people might not know what training is like in a certain specialty in Wales, I don't know what the training is like in Mersey, to be honest with you. So it works both ways.

[223] **Dawn Bowden**: Sure. I was just interested to hear the comments you were making about apparent perceptions from outside of Wales as to what it's like in Wales, and that might be something we need to reflect on. Thank you.

[224] **Dai Lloyd**: Julie, a oedd gen ti gwestiwn?

Dai Lloyd: Julie, do you have a question?

[225] **Julie Morgan**: Yes, that was one of the things I was—

[226] **Dawn Bowden**: Sorry, Julie.

[227] **Julie Morgan**: No, that's fine. I was thinking about the perception that you've referred to, and I wondered if the issue of the rurality of a large amount of Wales featured in the perception of people who were thinking of whether to come to Wales or not.

[228] **Dr Parish**: We're a deanery—there are seven deaneries, and they're all a fair size, but we're a massive geographical area. So, I think if somebody was going to—. A lot of people in medical school I remember saying, 'Oh my God'—and even I thought it as well, you know—'I'm going to stay here but I'm going to have to go to north Wales for a year and then I'm going to have to move back.' I mean, that's a massive move. I'm sure I would have enjoyed it, and I would have done it, but in the back of my mind then I had, 'If I'm going to have children, what would I do with them, as it's uprooting the whole family?' Equally, I'm no more special just because I've got children—just because I've got them, why should I stay down more than somebody who has and has to go up there instead of me? It's quite difficult, but what they've done—and I don't think it's very well advertised—for paediatrics and, it sounds like, for emergency medicine, means that I'll never leave south Wales now unless I actively ask to go to north Wales. So, I'm guaranteed to be able to commute from wherever I live, and I think that's a big thing and could be advertised a lot better.

[229] **Julie Morgan**: And that's quite recent, is it?

[230] **Dr Parish**: For paediatrics, it's maybe three or four years ago that they changed. So all their tertiary things are going to—like a tertiary neonatal unit that takes 24-week babies et cetera—they go to Alder Hey and another hospital up there, whereas I can go to Cardiff, Swansea or Newport. Well, not Newport anymore, as they've taken us out of there, but, you know, that, for people to come, in is probably quite a significant thing. Obviously, I don't want to divide Wales—we're one big nation—but as a geographical deanery, we are massive, and I think that might put people off if they don't know that you can stay in an area. It would put me off, anyway.

[231] **Dr Williams:** I don't think in emergency medicine there's a guarantee that you can say south Wales and south Wales and north and north, but on the whole, if you ask to be in south Wales then you probably will get most of your placements in south Wales, and vice versa; it's not written down, but it's effectively what happens.

[232] **Dr Roberts:** There are some specialties where people have to move between north and south Wales for the experience, and often it becomes a problem when people are given two weeks' notice that they have to move, and that is a problem that we—

[233] **Julie Morgan:** Two weeks' notice?

[234] **Dr Roberts:** Yes. So, people have to wait until their end-of-year reviews to see what they've already done and what they need to be doing. So, one of my colleagues was potentially having to move to north Wales at two weeks' notice.

[235] **Julie Morgan:** And what about family circumstances? Is that taken into consideration at all in that?

[236] **Dr Roberts:** No.

[237] **Julie Morgan:** So, have any of you experienced this at short notice?

[238] **Dr Davies:** I've experienced going to the ARCP, which is like the annual review process, and not knowing where I'm going to be sent. Usually, it's a bit more notice than two weeks, but it can be about four to six weeks and I'm coming home to my wife and my wife's saying, 'Well, where are you going?' But I do get used to it. I just got to the point where I accepted that to a point. And then at one point I was told, 'You need to go to Liverpool for a year, and then you'll need to go somewhere else in England for a year', and then I come home and my wife said, 'Well, you're not going and that's that.' [*Laughter.*]

[239] **Julie Morgan:** So, you didn't go.

[240] **Dr Davies:** No, I didn't. She said, 'You're not'.

[241] **Dai Lloyd:** Angela, you had a point here.

[242] **Angela Burns:** I just wanted to clarify this training. Having read the responses in your paper, it's really interesting what people are putting up as either barriers or pluses or minuses. But this is your training that would take place in a hospital—those were, in the main, all of these responses, rather than people's views on the training that they would receive within a medical school.

[243] **Dr Williams:** Those responses there are purely for people on the emergency medicine specialty training. So, it's people from ST1 or CT1—core training 1 or specialty training 1—up to ST7 or ST6.

[244] **Angela Burns:** So, they're already in the hospital environment.

[245] **Dr Williams:** They're in hospital. And then, normally, you get notice of being within a group of hospitals for lower training and for higher training; it's normally split up.

[246] **Angela Burns:** And because of the geography, is there—? What would be your views on either—? Can we keep all of our training in north Wales across our band of hospitals there, or would it be more feasible for us to look at trying to create properly integrated training between north Wales and the lower Merseyside hospitals?

[247] **Dr Williams:** I think it's probably got to be a multi-angle attack to that, and so you're probably going to have to look at trying to encourage more training locally. You're probably going to have to look at creating more links with Merseyside, and you're probably going to have to see whether more could be done to bring our north Wales trainees down to south Wales. I think it has to be that, because I don't think there are enough trainees up there—nor trainers, in terms of that we've got only 64 consultants in our speciality in Wales, and the vast majority of them are in south Wales. So, those in north Wales who are interested in training—it's actually quite low for it to be provided up there. I think that's probably something I can't answer, but something I think probably our head of school could answer instead.

11:15

[248] **Angela Burns:** Would any of you be prepared to give a view on what you think about the current geographical location of our medical schools in Wales?

[249] **Dr Williams**: I think if you were to look at the number of placements—. One of the things that we've had problems with in our new emergency medicine degree is that we had to look to where we can place the students. You've got to bear in mind that the vast majority of placements would be in south Wales across the south Wales M4 corridor. So, having a medical school in Swansea and Cardiff, to me, makes sense. I know there's the question about maybe a medical school in north Wales.

[250] **Angela Burns**: I didn't want to put the words into your mouth, but I just wondered what you thought.

[251] **Dr Williams**: I think you've got to look quite carefully there at whether or not there's enough clinical placements available, because one thing you don't want to do is to overload a department or overload a speciality with too many medical students, because the quality of the teaching would then reduce, and the quantity as well. But, that's not to say that that can't be done in north Wales, but I think that's got to be looked at quite carefully.

[252] **Angela Burns**: But if we were to look at it in conjunction with building that integrated service with the Merseyside area, would that work? Or do the medical schools up there already suck up—

[253] **Dr Williams**: Are you referring to undergrad medical or are you referring to speciality?

[254] **Angela Burns**: The undergrad.

[255] **Dr Williams**: When I was talking before about Merseyside, that was just with postgrad, with Merseyside taking some of our trainees from north Wales. 'I don't know' is the answer for undergrad. I would be guessing.

[256] **Dr Roberts**: I wonder actually if the issue is looking at how many Welsh-domiciled students are actually accepted into the existing medical schools we have. As someone who had to go elsewhere to train, my form tutor was very angry about this and looked into the figures. I think the intake was under 20 per cent, that year, of Welsh-domiciled students. So, if there were to be an extra medical school in Wales, if it's not actually attracting Welsh-domiciled students into it, then it may have no impact on recruitment, ultimately, in any case. In Scotland, I'm told that they have a sort of ring-fenced number of places for local students. I'm not quite sure how that

works, but I wonder if that would be worth looking at.

[257] **Angela Burns**: Funnily enough, because of my constituent, I've already started this hare-chasing, because it does concern me. I know that, when we talk about these issues in the Chamber, one of the big pieces of evidence that's always cited is the fact that people tend to, because of all the reasons you've said, settle where they train because, by then, you've started to build up your networks. So, if we can keep more of our people who want to stay in Wales in Wales, then we might have more of a chance, going forward.

[258] **Dr Parish**: I think that's the one thing that needs to be done.

[259] **Dr Williams**: Over the last two years, there's been roughly around 60 per cent—from both Cardiff and Swansea graduates who are then going into F1 positions—that stay within Wales. That's the figure that I've heard.

[260] **Angela Burns**: About 60 per cent, okay.

[261] **Dr Williams**: Yes, which I thought, personally, was quite reasonable, if that figure's right—I'd have to check.

[262] **Dr Davies**: I wonder whether Swansea would make a natural experiment for what might happen in Bangor, because I think a few years ago the degree changed fully to Swansea. It'd be interesting to know where those students go. Do they go across to Hywel Dda now, because that's potentially commutable from Swansea, a lot of it, or do they still want the bright lights of Swansea? They may already be settled there because of their postgraduate course. They may be coming towards the end of their actual medical student training, already settled, buying houses, with families, and not in that period of life where you do tend to want to go elsewhere. That may be an experiment that's worth looking at and seeing if that is successful. Potentially, that could be replicated in Bangor, and supply and demand in those regions in north Wales as well.

[263] **Dr Parish**: I'm a Swansea graduate. In my first year in Swansea, there were only 35 students, and then it went up to 70. I don't know what it is now, but 70 is probably a manageable number to have in north Wales without overpowering the universities there. I did stay—literally, with my first pay check, that's when I bought my house, because I was 26. I was a bit older than all the 23-year-olds in Cardiff that were graduating. My life was in a slightly different place. It would be interesting to see where everyone's

settled. A lot of people ended up going back to where they were before, that's the only thing—the people I knew.

[264] **Dr Williams:** Even though I've mentioned that 60 per cent figure, I'm pretty sure that, in 2012 there was—. When we choose which deanery we're going to, we don't just say, 'We want to go to this deanery'. We have to rank the deaneries. Even though that sounds like quite a high percentage coming into Wales, I think that in 2012 we were twentieth out of twenty-one deaneries on the ranking list for first choice. So, even though we might retain a few, it might be that people put it down as second or third and tend to get it because you get fewer applicants to Wales, which is a problem.

[265] **Dr Roberts:** Even with foundation training, there's a huge drop-off at the end of your second year. So there's a compulsory two years after qualification and foundation training, and we're now seeing a huge drop-off after F2—that people then don't go into specialty training. So you could finish your foundation training in Wales and then not stay here. People take career breaks and go off to Australia and do lots of different things. We're seeing that, actually, big numbers in foundation training do not necessarily translate into specialty training.

[266] **Angela Burns:** Can I just—? It kind of comes onto the career development, is that all right? I just wanted to pick up on the point about Hywel Dda and Swansea and stuff. Because, again, some of the evidence we hear is that for the more rural health boards—. And you're talking about this; at least three of you specialise in particular—you are not generalists, but are obviously highly trained specialists. People don't want to go to the more rural health boards because they don't see—. And I only say that because I don't know what your specialities are. They don't want to go to the more rural health boards because they don't have the numbers to keep the speciality training up. So if you're a paediatrician you've got to be able to see a certain number of babies every year. If you want to be a neonatologist you've got to be able to see a certain amount of that. So, that's why we struggle so much in the more rural environment. When we talk about career development and where people want to settle, how much of a factor does that play on you? If you're settling in an area, do you think, 'Well, actually, in four or five years' time I think I want to go down this speciality route, or that speciality route'? You look at the lovely area that you're in but you think, 'Actually, these hospitals are not going to provide me with enough of the practice that I need in order to achieve that'. I just wondered how much of that really factors into your thinking at an earlier stage.

[267] **Dr Williams:** It's factored into my thinking. Within our training, in lower training we have six-month placements and then we have year placements—or they tend to be around that—for higher training. It's made sure, and I'm sure probably in most specialities as well, that we are in tertiary hospitals for some of it, so we see our traumas and we see the types of cases that come in there, and then we're also in a DGH as well, so we get an experience of both. Then, I suppose, it's all down to your personality, isn't it, so I'm not sure I can really answer that, because whether you want to work in a DGH with a different caseload and different types of cases coming through, or whether you want to be in a tertiary hospital, is all down to the person. Along with that, after working six months in an area, you know the area, so you build that kind of impression up, so I think it's very much a personal choice.

[268] **Dr Davies:** I think you're not going to know that at the age of 23 either, and that's one of the problems. Not only do you change, but also the job can change. When I started general surgery, it was still a mentorship and a firm-based structure, which was great and I loved it, and then when I left it became shift work. I didn't know that was going to happen when I was 23. So you've got that thing as well. But I think what you said about that was right; you get some experience in the tertiary centres and different experience in DGHs. Also, sometimes in tertiary centres you may actually do less operating, for example, in a surgical specialty, while you might do a lot more in the DGHs, but in tertiary centres you might have access to the research and academic side. For example, if you're going to do a higher degree—and that might be another way of attracting people to Wales: offering those high-quality higher degrees at the established universities. There's no reason why you can't be working somewhere, for argument's sake, in Hywel Dda, but do a degree linked to Swansea or Cardiff if you had some freedom to attend some sessions. That might be quite attractive to people, depending on what they wanted to do. Obviously, the GP workforce would be a very different story again, but for hospital-based—.

[269] **Angela Burns:** I think what I'm trying to slightly bottom out is the tension between what you as careered professionals want to try and achieve and what the denary and the royal colleges are all saying, because they're all sort of coming in, but they're not quite matching up. So, if we were to take the Hywel Dda scenario, and if we were to look at paediatrics, then what the royal colleges say is that in order to complete your paediatric training—I think it's you've got to deal with a minimum of 2,500 births a year, or you've

got to be in a hospital setting that deals with 2,500 births a year. And a hospital could be over a couple of sites, maybe; it depends how far apart they are. So, Hywel Dda has really struggled and is struggling to keep maintaining that paediatric training.

[270] **Dr Roberts:** They don't go there.

[271] **Angela Burns:** No, because it doesn't fit that criteria. That's something the royal collages have said. In order for you to be the best you can possibly be, you must have this experience, so then it hits against the health board that says, 'With the best will in the world, we can't make more people have more babies more quickly.' So, we're stuck. We can't do the training. But then you might have a person that says, 'Actually, I really want to have that environment, I want to be able to settle down here and bring my kids up here.' So it's just trying to marry all those tensions. And, of course, who loses out is you lose out, because you're not where you want to be, and the public loses out because they're not getting the services they want because of all of these developments in medicine, developments in attitudes, subspecialisations. So, how we marry it all together I haven't got a clue, but it's trying to understand what impact it has on you guys.

[272] **Dr Roberts:** New Zealand have rural medicine as a specialty, so I'm not sure how that could translate to all the different specialties that we have to provide training for within Wales. I know of someone who trained in Birmingham as an undergraduate, did her foundation years there, and was specifically attracted to Wales on the basis of a rural GP course that she went on. So, it is something that you can make quite a big deal of. How it then maps out to provide training in every single different specialty is a bit of a tricky issue, and I think, also, when you're thinking about who wants to go to the rural areas you also need to think about who they bring with them as well. It's often difficult for people, when they want to go and work in the middle of Powys, for example, if they have an other half whose job isn't so transferrable. Yes. It's quite difficult.

[273] **Dai Lloyd:** Dawn, you had an issue.

[274] **Dawn Bowden:** It was only just picking up, I think, on Huw's point about the choices of deaneries, and you were saying that, in general, you get to choose. You rank the order that you'd like to—so, one, two, three. You said Wales Deanery comes usually twentieth out of the 21 deaneries, in terms of choices.

[275] **Dr Williams:** From some work I did a little while ago, I'm sure it was twentieth out of 21 in 2012. I'm just pulling that from the memory banks.

[276] **Dawn Bowden:** So, forgive my ignorance in how this works. So, you choose, or you make a choice of your preferred deaneries, at what point—.

[277] **Dr Williams:** So, as you graduate from medical school, you—

[278] **Dawn Bowden:** So, as you've graduated from medical school. So, are the deaneries, then, all vying for you at medical school—

[279] **Dr Williams:** Are they all what, sorry?

[280] **Dawn Bowden:** Are they vying for you, are they advertising their wares at the medical schools or not? How do you get to know about them, is, basically, I suppose, what I'm asking. How do you come to your choices?

[281] **Dr Williams:** I can't remember—

[282] **Dr Khan:** Online, I think they have the NHS website—

[283] **Dai Lloyd:** It's an all-UK application process, isn't it, for further training—

[284] **Dr Khan:** Oriel—it's called the Oriel website. There are all these different sorts of rotations. So, then you select each and every one, wherever you want to go, but there is a mixture—you can't jump from one to another. For example, if you're going for core training, they offer you four rotations of different sorts. So, you select them, and then you go to that—

[285] **Dawn Bowden:** I see. I was just wondering why it was that Wales was so low on the choice, which may come back to some of the earlier points that you were making.

[286] **Dr Roberts:** In the old days, you used to have jobs that were linked to your medical school. So, I qualified before foundation training, so you had specific jobs that you would just apply to that were linked to your medical school. I'm sure Cardiff would have had exactly the same thing. That's slightly different now. But I wonder if the application system for specialty training also hinders recruitment in rural areas, because of the way that you

rank your preferences. I applied to the big deaneries to begin with, and then when you have your interview—so, I had an interview in the Wales Deanery—you then rank your scheme and where you want to go within Wales. But you can jump—so, they might be struggling to recruit in Pembrokeshire, but if you rank somewhere else above that and your ranking gets bumped up as people drop out of the scheme, you completely bypass those rural schemes. So, the places that are struggling to recruit, you then can't opt in to going there, because you kind of jump over them. It's really difficult to explain how badly organised the system is—but, yes, it's possible to completely bypass these schemes that are struggling to recruit because of the way the application process is set up.

[287] **Dr Williams**: I think that system has changed since I've come from medical school as well. Going back to that twentieth out of 21; that was back in 2012. That's not to mean—I'd imagine that might have been a lot of people putting their home, where they grew up, as the place to go to as their first choice, perhaps, and Wales very well might have been second choice for an awful lot of people. I'm just talking about the first choice, and that was, as I said, a long—it was five years ago.

[288] **Dawn Bowden**: Okay. Thank you.

[289] **Dai Lloyd**: Lynne, did you have a question?

[290] **Lynne Neagle**: It's not No. 11, is it?

[291] **Dai Lloyd**: No, it's not. They're not numbered, Lynne. It's the one about—

[292] **Lynne Neagle**: That's what I thought. Sorry. No, I'll leave it. I'll pass on this one, thank you.

[293] **Dai Lloyd**: There we are. Let me pipe in while people are thinking. In terms of, at the present time—. Going back to earlier times in your careers, when you were still at school, i.e. secondary school, nowadays less than 20 per cent of the medical students in Cardiff and in Swansea come from Wales, whereas medical schools in Scotland universally have more than 50 per cent or 55 per cent of their medical students coming from Scotland, and medical schools in England also have similar or higher percentages. What do you think about those statistics for Welsh medical schools, as regards developing the next crop of junior doctors for this nation? I don't know who wants to

take that on.

11:30

[294] **Dr Davies:** When I was in school, we had careers advice, and the careers adviser told me, and I quote, 'You're not going to be bright enough for medicine—you should go into NHS management'. That's what I was told in school. But, if that's—. There need to be some links with the schools to get people from a diverse background, definitely, and those people are more likely to stay because they've got family locally, childcare arrangements in future life, and all of the rest of it, but how do you do that?

[295] The other side of that is that there's a massive, massive financial implication of sitting medicine in the first place, not only to put yourself through five years of student life with no grant and build up a massive student loan, which may well be as high as £40,000 coming off, even in Wales—you know, £40,000—but then supporting your postgraduate training thereafter, depending on what you're going to do. If you're going to do a surgical speciality, for example, every training course is, basically, £1,000. I think that, at the last count, the deanery allowance was £450 or £500 per annum. Every course is £1,000, and that's without accommodation and all of the rest of it. You pay yourself. To begin with, you pay yourself. But, then, when you have a family, that becomes harder because you're not giving away your money, you're giving away your family's money, and that becomes much, much harder. So, I think the only problem with that recruitment in schools is are people are going to be scared of that financial implication, and with the political way things are at the moment, the price of fuel and all of the rest of it, there's a massive—. I don't know. That's a real worry.

[296] **Dai Lloyd:** That's fair enough. Lynne has now got a question.

[297] **Lynne Neagle:** I have, yes. I'm not asking you to be party political, and this isn't a party political point for the sake of it.

[298] **Angela Burns:** I can take it. [*Laughter.*] I know exactly what you're going to ask. Funnily enough, I was going to ask it as well, because I am brave.

[299] **Lynne Neagle:** Right. Okay. Obviously, there is a very different approach to public services and the NHS in England and in Wales. As I say, I'm not asking you to be political, but the Welsh Government has made much

of the fact that we haven't had a junior doctors' strike here, et cetera. There's been different legislation in England—the Health and Social Care Act 2012—and there's a different ethos here. How important is that to you, or even how important do you think it is to people who are thinking of where to train and where to work, that kind of ethos about public services?

[300] **Angela Burns:** Before you answer, can I just build on that slightly, as well, to say that, the differences in the contracts between the two countries, do you think the divergence will carry on growing, and would that then become an impediment to the flow? Because we see it in education, where it's slowed down that flow between the two countries of professionals, because we're forming quite different systems. Would you ever see that happening in medicine, or do you think that medicine is, excuse me for saying this—I'll sound such an amateur, but I am an amateur—'a body's a body, there's a lot more stuff that joins rather than separates'? And you can be political—I can take it. [*Laughter*.]

[301] **Dr Roberts:** I think the contract issue is particularly relevant at the moment. The BMA Wales junior doctors committee recently conducted a survey, and we had—I can't quite remember the figure, but it was well over half of our respondents who said that the contract issue had been a significant factor in their decision to come and work in Wales. As things stand, there is a lot of frustration in England at the way that the contract imposition has been handled. We're very pleased that we're not facing the same imposition in Wales, and I think, as things stand, the way that our contract is working currently, and the same for Scotland and Northern Ireland—we all still have the same existing contract—that is a very positive thing to get people into Wales.

[302] **Dr Williams:** One of the questions that we asked in our survey to the All-Wales School of Emergency Medicine trainees, of which we had quite a high response rate of around 90 per cent—we asked the question, 'Have the recent changes in medical contracting discouraged you from completing your training in England—i.e. did you want to move across to finish your training?' Two thirds said that yes, it had discouraged them, and one third said 'no'. Personally, for me, I haven't considered it, because I would want to stay here.

[303] **Angela Burns:** Going back to your comments, Abby, about wanting to develop your neonatal skills, would that be a barrier to stop you from then going off to do your career development and your subspecialisation? And, with the other hat on, if you were in an English health board and you were

signed up to the English contract, I'm assuming that that obviously means, in fact, it makes transitioning to Wales easier, mentally.

[304] **Dr Parish**: I would never actively choose to go to England. I do not want to be a part of the English NHS or the junior doctor contract. If I have to go, though, to be honest I'm just going to have to go and, basically, suck it up and just do it, and that's kind of what we have to do. We all have jobs that are a poor experience and we can try and fight for whatever cause we've got during that point, but we rotate jobs so often, and we have to put up with various things in different jobs, that I think we're quite a resilient bunch, and that's what they've relied on with the imposition, that we'll just go, 'Fine. We'll just have to do it, then'. I don't know anyone in England who's left medicine because of it. I know some people who have actively chosen to come here for the subspecialty process. One girl, who's coming for emergency medicine, actually, in Cardiff, she said she chose to leave London because of the contract. So, she's coming in September. There are quite a few people who've come because of it.

[305] In paediatrics—this is obviously all paediatric-specific from me, but, the deanery, there's been a lot of improvement in our training, our exam pass rates and our morale over the last few years. So, from the General Medical Council surveys that come out every year, we get ranked. I can't remember what Wales Deanery were—I think it was quite high—but Wales's paediatrics deanery was the highest deanery. And, for the second year running, for the first time in a long time, recruitment at ST1 level, which is the first year of paediatric training, has been filled both times. They haven't offered the places this time, but enough applicants applied to take all the jobs, whereas, in previous years, they weren't filling jobs.

[306] **Angela Burns**: That's good, then, isn't it?

[307] **Dr Parish**: That's not all junior doctor contracts—that was starting beforehand—but it does put you off wanting to leave.

[308] **Dr Davies**: Interestingly, the person you're talking about who's come back to do emergency medicine here is actually someone who was a Cardiff graduate, who'd gone to England and has come back. So, this is someone who is coming back.

[309] **Dr Khan**: I had many colleagues in Peterborough who left. Some of them came to Wales and some of them went to Scotland. But I think they

were quite—. About 10 per cent or 15 per cent of them stayed in England. The rest of them left because of the new contract. They didn't want to stay where they were.

[310] **Angela Burns:** So, obviously there's the big difference in the contract—the terms and conditions of employment, et cetera. Is there any sort of difference or divergence happening—? You've talked about the fact that in Wales you've felt that you've had more support in your training. Because of the royal colleges, does that mean, then, that there's actually no difference though in training? So, if you're going to be trained in this speciality, whether you're being trained in Peterborough, or whether you're being trained in Swansea, you're going to get the same kind of training, so that the essence of the training and the practice of medicine in Wales, England, Scotland and Northern Ireland will always stay pretty much the same, but it's the underpinning underneath it, the terms and conditions, the support, the delivery of it, that will change within countries.

[311] **Dr Williams:** The competencies for a speciality, whether you're in England or Wales, are dictated by the royal college and therefore you are trained to a certain level, but your experience could be vastly different, and how easy it is to gain those competencies could be vastly different as well. And that's not just a vast difference between the deaneries, but a difference between the different departments you might be in.

[312] **Dr Parish:** So, if we were both paediatricians or ED, our training could be the exact opposite because we'd been in different places, as with any sort of job, really, isn't it? In my experience, I think the training here is great; I've got people who don't think it's so good, you know, and we're on the same training programme. It's about our expectations and our experiences, isn't it?

[313] **Angela Burns:** I've just got one more question.

[314] **Dai Lloyd:** One more question, Angela.

[315] **Angela Burns:** Thank you. It's totally different, because I understand that you are all hospital professionals, or all specialising in hospital practice.

[316] **Dai Lloyd:** Apart from one—a GP.

[317] **Angela Burns:** Oh, a GP. Great, because this is—. General practice—the

face of general practice is obviously changing enormously, and I just wondered if, through either your own evidence or anecdotal evidence from people who you know who've trained and gone down the GP route, there's a difference about whether people are happy to buy into and become part of a practice, or whether, actually, people would much prefer to go down the salaried GP route.

[318] **Dr Roberts:** From my cohort—. So, I qualified two days ago—that's when I started; I qualified in August, because I took an extra six months—

[319] **Angela Burns:** Congratulations.

[320] **Dr Roberts:** Thank you very much. And none of my cohort are partners. Two people became salaried GPs out of 14 of us, I think. So, two became salaried GPs in August. The rest have been locuming, and that is my plan as well. I'm not going to make any rash decisions about committing to anything at this stage.

[321] **Angela Burns:** And do you think there's a trend within the GP workforce for more and more people to say, 'Actually, we don't want to have the practice element. We would much prefer to be locums or salaried GPs'? What I'm really trying to drive at—I just wonder if in 10 years' time, when we look at the landscape, we will actually see a real dwindling of practices because of the enormous costs of investing in a practice—buildings et cetera. It's not just your core function; it's everything else that you have to have as well.

[322] **Dr Roberts:** I have a slight bee in my bonnet about this. I think it comes down to training, and if trainees feel abused during their training—because a lot of people tell me that they see themselves being used as an extra pair of hands—. So, there is a GP trainee contract and you're contracted to work 40 hours a week. When I was full-time, I wasn't—I was working closer to 50 hours a week, and that's particularly irritating when you have a contract that says that you should be doing 40 hours a week. The problem is that lots of senior GPs see your training as an opportunity to get to know the real GP. So, it doesn't matter what your contract says, you do what the GPs do, and that's that, because, otherwise, you have no idea what it's like to be a GP. So, I think there is a creep in how much service we're expected to provide.

[323] I dropped down to less than full-time working after three months in

my final year of training, and I think if I hadn't done that—. It was for British Medical Association work, but the BMA work was partly an excuse to go less than full-time because I would have just been burnt out with 50 hours a week of working every single week, and a lot of my colleagues feel the same. So, you come out of training, you have a significant number of assessments to do in your final year of training, there's a very expensive exam to sit—it's £1,600 to sit and you pay for that yourself, and if you fail, you have to pay an extra £1,600 to sit it again—and the number of patients you're seeing are increasing as well. So, the day-to-day work gets busier, you have more assessments to complete and you have difficult exams to do. So, people finish their training and they feel a bit burnt out, and I think that's what's contributing to the working patterns—that people are just tired of being bossed around and they kind of want to be their own bosses for a little while. So, people will then eventually drift into becoming salaried GPs, but I don't know anyone on my scheme who is even talking about becoming a partner.

[324] **Angela Burns**: Wow, thank you.

[325] **Dr Davies**: Can I just add that my wife became a partner about a year and a half ago, and she was straight off a training scheme and did go into a partnership. There are benefits to that because you don't have to drive somewhere different every morning. So, actually, there's a bit of peace of mind. We moved house because of her job, so the only problem now is if I don't get a job in Wales then we might have to move again. So, some people do still do that.

[326] **Dai Lloyd**: Lynne.

[327] **Lynne Neagle**: I just wanted to ask Bethan, really—so, if the Welsh Government was going to, say, have a big strategic push towards really increasing the number of salaried GPs, as opposed to investing so much in the contractor model, you don't think that would put people off coming to do their training and working in Wales?

[328] **Dr Roberts**: I'm not sure whether there needs to be a big push towards salaried GPs particularly. I think if there could be a focus on optimising the training and making sure that trainees were working within their contracts, because, initially, coming up now in England, GP trainees in practice will be able to submit reports—. If they're working beyond their hours, they will be able to submit reports that will be scrutinised by an external agent who can then either authorise extra payment, or say to the practices, 'Stop doing

this'. There is no mechanism for that now in Wales. So, hospital doctors can do this exercise to monitor their hours, but GP trainees in practice don't have that. I think, probably, what needs to be fixed is how trainees are treated, particularly during their final year of training when it's very intense, to make them more likely to want to work in independent contractor models or as salaried GPs rather than coming to the end and thinking, 'I've had enough of this; let me just go and be my own boss.'

[329] **Dr Khan:** Can I just add, regarding the training hours, like in hospital training, we definitely really work more than the recommended hours of 40 hours? But whenever the exercise timesheet comes out, even if I work until 7 o' clock, at the end of that time period, you get an email that the time period, the working hours, have been met and nobody's worked extra hours. That was the same in Peterborough—literally, I used to go home by 7.30 p.m. instead of 5 p.m. It's the same here in Wales, so I think it hasn't changed much. It's still the same for hospital doctors as well as GPs.

[330] **Dai Lloyd:** Rhun.

[331] **Rhun ap Iorwerth:** A gaf i ddod yn ôl at y testun sydd wedi cael ei godi'n gynharach ynglŷn â pha bryd i dargedu pobl? Fe gawsoch chi eich perswadio—fe aethoch chi i mewn i feddygaeth—ond ym mha gyfnod yn yr ysgol a ddylai pobl gael eu targedu yn bennaf i'w cyfeirio nhw, gobeithio, tuag at nid yn unig meddygaeth ond gyrfaoedd eraill o fewn y proffesiynau iechyd?

Rhun ap Iorwerth: Could I just go back to a subject that has been raised already on when we should target people? You were persuaded—you went into medicine—but at what stage in school should people be targeted to refer them, hopefully, not only to medicine but also careers within the health professions?

11:45

[332] **Dr Roberts:** Siŵr o fod lot cyn TGAU, achos mae angen lot o waith i gael y graddau i fynd mewn i feddygaeth. Fe wnes i benderfynu pan oeddwn i'n 11 fy mod i'n moyn gwneud meddygaeth, so fe wnes i'n siŵr fy mod i wedi gweithio i gael beth oedd angen ei gael. So, ie, fe

Dr Roberts: Probably a lot before GCSE level, because a lot of work is required in order to get the grades you need to go into medicine. I decided when I was 11 that I wanted to do medicine, so I made sure I worked hard to get what I needed. So, yes, I think it definitely should be

ddylai fod yn gynnar.

very early on.

[333] **Dr Parish**: I decided when I was 20 to become a doctor, because when I was 14 in school I said to my biology teacher, 'My grandad said I should be a doctor', she was pretty much—. And my careers advice—I mean, this was in 2000 or 1999—was, 'Oh, Abby, just go to university, get a good degree and you can get a job in anything.' I think it should probably be year 9, so you can choose your right GCSEs and start getting involved in things like the Duke of Edinburgh Award and all these other projects, and get some good quality careers advisers in.

[334] **Dr Williams**: Same reason—it was year 9 when I roughly decided, just before GCSE level.

[335] **Dr Davies**: I fynd nôl at beth wnes i ddweud am *careers advisers* yn yr ysgol o'r blaen, efallai eich bod chi *actually* angen pobl o *healthcare* neu o *medicine* i fynd mewn i'r ysgolion i siarad gyda'r plant, achos nid yw *careers advisers* yn gwybod. Nid yw'n deg iddyn nhw wybod, efallai. Ond, ie, cyn TGAU, achos rydych chi'n gorfod cael digon o bwyntiau TGAU *anyway* i gael yr *A-level courses* cywir.

Dr Davies: Going back to what I said about the careers advisers in school before, perhaps there is actually a need for people from healthcare or medicine to go into schools to speak to children, because careers advisers just don't know. Perhaps it's not fair for them to know either. But, yes, I would say before GCSE, because you have to have enough GCSE points anyway to have the right A-level courses.

[336] **Rhun ap Iorwerth**: Ac mi fyddai *roadshow* o ryw fath sy'n mynd o gwmpas ysgolion Cymru yn gwerthu'r proffesiwn iechyd—*bells and whistles*, gwneud iddo edrych yn secsi i'r plant sy'n meddwl i ba gyfeiriad i fynd—a fyddai'r math yna o beth yn gweithio?

Rhun ap Iorwerth: And maybe a roadshow of some kind that goes around schools in Wales would be a way of selling the heath profession—bells and whistles, and make it look sexy to the children who are trying to think what direction to go in—do you think that would work?

[337] **Dr Davies**: Y math yna o beth, ac efallai *links* i'r ysgolion sydd efallai yn yr ardaloedd mwy *deprived* fel eu bod yn gallu gwneud *work experience*, achos mae hynny yn

Dr Davies: That kind of thing, and perhaps links to the schools that are perhaps in more deprived areas so that they can do work experience, because that can be very difficult

gallu bod yn anodd iawn heb gael y *links* i mewn, ac efallai bod y *services* i wneud hynny yn fwy anodd i bobl sydd yn yr ardaloedd mwy *deprived* nag efallai i'r ysgolion sy'n gwybod beth maen nhw'n ei wneud—sydd gyda system '*target Oxbridge*' o'r dechrau. Ond nid wyf yn siŵr sut i wneud hynny.

without having the links, and perhaps the services to do those are more difficult for those in areas that are more disadvantaged than for the schools who know what they're doing—who have a 'target Oxbridge' system from the beginning. But I'm not sure how to do that.

[338] **Dai Lloyd**: Grêt. Wel, dyna'r hyn rydym ni'n mynd i'w awgrymu i bobl sydd gyda'r arbenigedd yna i ddatrys yr union broblem yna, felly diolch am amlygu'r peth.

Dai Lloyd: Great. Well, that's what we'll suggest to those people with that expertise to solve that very problem, so thank you for highlighting those issues for us.

[339] Byddwch yn falch o nodi bod y sesiwn gwestiynu yma ar ben nawr. Diolch i chi gyd am fod yma yn y lle cyntaf, a hefyd am rai papurau sydd wedi cael eu paratoi ymlaen llaw. Diolch yn fawr i Dr Williams, a hefyd diolch yn fawr am ateb y cwestiynau mewn ffordd mor raenus ac mor aeddfed. Yn amlwg, mae yna ddyfodol disglair o'ch blaenau chi i gyd yn y byd meddygaeth, a thrïwch aros yn fan hyn, nid fel rhai ohonom ni sydd efallai yn trosglwyddo dros ambell i ffin arall. Felly, diolch yn fawr iawn i chi am eich presenoldeb, a hefyd fe allaf gyhoeddi y byddwch yn derbyn trawsgrifiad o'r sesiwn yma er mwyn i chi gael ei wirio i wneud siŵr ei fod yn ffeithiol gywir—nid eich bod chi'n gallu newid eich meddwl am ddim byd, ond jest gwneud yn siŵr mai beth rydym ni wedi ei gofnodi ydy beth roeddech chi'n bwriadu ei ddweud yn y lle cyntaf. Felly, diolch yn fawr iawn i chi

You'll be glad to know that the questioning session is at an end. Thank you all very much for coming here, and also for some papers that have been prepared in advance. Thank you very much, Dr Williams, and also thank you also for answering our questions in such a mature way. Clearly, there is a very bright future for you all in the world of medicine, maybe not like some of us who have transferred to other areas. So, thank you very much for coming, and can I also let you know that you will receive a transcript of this session so that you can check it for factual accuracy—not that you can change your mind about anything, but just to make sure that what we've noted was what you intended to say? So, thank you very much for coming today, and good luck for the future in our career here in Wales. Thank you.

am eich presenoldeb, a phob lwc am y dyfodol yn eich gyrfa yma yng Nghymru. Diolch yn fawr i chi.

[340] **Dr Roberts:** Diolch yn fawr.

Dr Roberts: Thank you.

11:48

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod ar gyfer Eitem 5
Motion under Standing Order 17.42 to Resolve to Exclude the Public from Item 5 of the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 5 yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from item 5 of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[341] **Dai Lloyd:** O dan eitem 4, a allaf i gynnig, o dan Reol Sefydlog 17.42, i benderfynu gwahardd y cyhoedd o'r cyfarfod ar gyfer eitem 5, sef i drafod yr adroddiad drafft ar Fil Iechyd y Cyhoedd (Cymru)? A yw pawb yn cytuno i fynd i sesiwn breifat? Diolch yn fawr i chi.

Dai Lloyd: Under item 4, can I propose, under Standing Order 17.42, to exclude the public from the the meeting for item 5, which is to discuss the draft Public Health (Wales) Bill? Is everyone in agreement to go into private session? Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 11:48.
The public part of the meeting ended at 11:48.

Ailymgynullodd y pwyllgor yn gyhoeddus am 13:01.
The committee reconvened in public at 13:01.

Ymchwiliad i Strategaeth Genedlaethol Ddrafft Llywodraeth Cymru ar Ddementia: Sesiwn Dystiolaeth 5—Cydffederasiwn y GIG
Inquiry into the Welsh Government's Draft National Dementia Strategy: Evidence Session 5—NHS Confederation

[342] **Dai Lloyd:** Prynhawn da ichi i gyd. A allaf i alw'r cyfarfod diweddaraf yma o'r Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon i drefn, o dan eitem 6: parhad efo'n hymchwiliad i strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia? Hon ydy sesiwn dystiolaeth Rhif 5, prynhawn yma, a'r sesiwn dystiolaeth gyntaf o ddwy. Rydym ni'n croesawu Cydffederasiwn y Gwasanaeth Iechyd Gwladol o'n blaenau ni. Rydym ni wedi gofyn cwestiynau i dystion o'r blaen, ac rydym ni wedi derbyn eich papur chi hefyd a'r dystiolaeth sydd gerbron—papur bendigedig, os caf ddweud. Mae'r Aelodau wedi darllen eich papur chi, wedyn fe awn ni'n syth i mewn i gwestiynau'n seiliedig ar eich papur ac, yn naturiol, yn seiliedig ar strategaeth ddrafft y Llywodraeth.

Dai Lloyd: Good afternoon to you all. I'd like to call this latest meeting of the Health, Social Care and Sport Committee to order, and under item 6 continue with our inquiry into the Welsh Government's draft national dementia strategy. This is evidence session No. 5 this afternoon, and the first evidence session of two. We welcome the NHS Confederation, appearing before us. We have asked questions of witnesses before, and we've also received your papers and the evidence that is before us—a great paper, if I may say so. Members have read the paper, so we'll go straight into questions based on your paper and, naturally, based on the Government's draft strategy.

[343] Felly, gyda chymaint â hynny o ragymadrodd, a allaf i groesawu i'r bwrdd Lin Slater, cyfarwyddwr cynorthwyol nyrsio bwrdd iechyd prifysgol Aneurin Bevan; Dr Suzanne Wood, ymgynghorydd mewn meddygaeth iechyd cyhoeddus, bwrdd iechyd prifysgol Caerdydd a'r Fro; a hefyd Nick Johnson, arbenigwr hwyluso gofal dementia, bwrdd iechyd prifysgol Abertawe Bro Morgannwg? Croeso i'r tri ohonoch

So, with those few words of introduction, may I welcome to the table Lin Slater, the assistant director of nursing, Aneurin Bevan university health board; Dr Suzanne Wood, consultant in public health medicine, Cardiff and Vale university health board; and also Nick Johnson, dementia care specialist facilitator, Abertawe Bro Morgannwg university health board? I welcome the three of you, and we'll start with the

chi. Fe wnawn ni ddechrau â'r cwestiynau, felly, ac mae gennym ni ryw dri chwarter awr. Mae nifer helaeth o gwestiynau, felly cwestiynau byr ac atebion byr a fyddai'n handi. Felly, y cwestiwn cyntaf—Jayne Bryant.

questions. We have about three quarters of an hour. We have a number of questions, so short answers and succinct answers, therefore. First question—Jayne Bryant.

[344] **Jayne Bryant:** Diolch. In the Wales NHS Confederation evidence that we've had, you say that the crucial role of carers—and I think it's so important that we're looking at the work of carers. I think in it you mention that

[345] 'we need to support people to participate in planning, designing their care with health and social care professionals'.

[346] Do you think the draft strategy does enough for carers and citing the role of carers?

[347] **Mr Johnson:** I've got to say we need to appreciate their role hugely, and I think we need to involve them as partners within the whole process. I think we need more engagement with them. I don't know whether you are having representatives from carers' associations giving evidence here as well, but, personally, no, I think they need to be more involved and given more support.

[348] **Jayne Bryant:** Any other comments? Okay, that's really helpful to hear. There are other parts of the evidence that say

[349] 'investment in the skills, capacity and well-being of carers should be prioritised'.

[350] Is that something that you feel is important?

[351] **Ms Slater:** Sorry, can I just make a comment for a moment? I don't think this is our evidence. We've provided evidence on behalf of our own health boards, but I think the Welsh confederation are providing evidence to you separately, and that's their paper.

[352] **Jayne Bryant:** Right, sorry. I was looking at the NHS Confederation.

[353] **Ms Slater**: We are NHS bodies, but I think—

[354] **Jayne Bryant**: Would you agree with the evidence?

[355] **Ms Slater**: Yes, indeed, I would agree with the evidence. I think what the strategy does is give us the opportunity to develop an integrated dementia care pathway. I think, on that, in the development of a pathway, what we need to include are the services and support that we can provide for carers. That's obviously a range of things that we need to do, from supporting our families when there is concern about a loved one having dementia, through to supporting them through a diagnosis, getting that early support, and also, as you've said, helping people to develop, sometimes, skills that they might need in order to look after people at home. So, there's a whole raft of things, but, of course, they're all different, because people are different, dementia is different, and circumstances of families are different. So, it's about having that person-centred approach. In terms of what the confederation has said, I think it is important to have services that wrap around not just the individual with dementia, but also family members and carers too.

[356] **Jayne Bryant**: How do you think that would progress when, obviously, people who have dementia, and their families, might start after a diagnosis of dementia with certain needs, but then, obviously, the carers' situation can deteriorate as well, later on into that, when dementia deteriorates?

[357] **Dr Wood**: If I could take that question, that would be great. So, locally, we've developed a carers education pathway, and it involves the Alzheimer's Society's Carer Information and Support Programme—CrISP 1 and CrISP 2. So, it follows the carers through both the beginning stages of a diagnosis and right through to end-of-life care to support them in the process. Locally, we've developed an education pathway to make sure that carers really do have the education needs that they would need through that journey.

[358] **Jayne Bryant**: Thank you.

[359] **Mr Johnson**: I would agree. If we can educate carers and families around the progression of dementia and things that we absolutely know are going to happen—. We know that, at some point throughout that journey, there are going to be hospital admissions. We know, throughout that journey, there is going to be a need for support and respite care that is meaningful to that family. That's not necessarily two weeks in a care home.

That is what they need—'What do you need?' We need to have those discussions. But I think that educating families and carers to be able to cope with those changes as they come, in a timely fashion, is something that we would definitely be welcoming. Because I think, ultimately, that will end up preventing, or delaying certainly, inappropriate referrals into a hospital setting, for example.

[360] **Dai Lloyd**: Julie Morgan, efo'r ail gwestiwn.

Dai Lloyd: Julie Morgan, with the second question.

[361] **Julie Morgan**: Right. Good morning. Do you think anything should be done to the strategy to strengthen access to care and help from groups with protected characteristics or groups who have different language needs? Could you give us your views on that?

[362] **Ms Slater**: I think one of the most important things is that people have access to their own language. For us, obviously, in Wales that means Welsh. So, we need to do more to make sure that people who work in public-facing bodies—certainly the health service—have access to Welsh speakers so that people can speak fluently to people, especially when they're in hospital and often distressed and need to speak in their native language. So, I think that's particularly important. We also need to be mindful of those people with sensory impairments as well, particularly loss of sight, and also those who have hearing difficulties, because, again, those people will have needs in relation to those things as well as to their dementia. We need to think sensitively how we can properly meet those needs.

[363] **Dr Wood**: I'd like to add to that, if I could. So, within Cardiff, for example, the black and minority ethnic population constitutes 16 per cent of the population. Therefore, not only would the Welsh medium be important, but other first languages in that context. So, wherever possible, they do offer a translation service in memory clinics and community mental health teams in order to support people in that way. So, not only do the language needs need to be supported, but also the cultural needs of that community.

[364] **Mr Johnson**: I think we need to do more as a society to engage, certainly with people not just from the BME environment but also lesbian, gay, bisexual and transgender as well. I think the real truth of the matter is that, at the moment, although there is a lot of evidence out there in terms of published reports, I don't think we really know what those needs are. I think there were a lot of myths around groups being difficult to engage with. I

think that that really is a bit of an excuse. I think we need to make more of a concerted effort in that regard.

[365] **Julie Morgan:** Do you think there needs to be a specific effort towards specific groups?

[366] **Mr Johnson:** I believe so, yes, I do. Otherwise—

[367] **Julie Morgan:** And how do you think this strategy could be strengthened in relation to that?

[368] **Mr Johnson:** I think it needs to refer back to successful—. There have been other successful programmes within the UK, where people have managed to reach out to those communities and develop those links, and I think perhaps we could link to that evidence or those schemes.

[369] **Julie Morgan:** Yes. You don't have any particular ideas of anything, because I'm sure things have been done in Wales as well.

[370] **Mr Johnson:** I think we need to have engagement events and reach out and find out what those issues are, because I think there are a lot of myths in that respect.

[371] **Dr Wood:** I concur with Nick. So, in terms of LGBT groups, definitely, engaging with that community is essential. Evidence suggests that, as you get older in the LGBT group, you're more likely to be alone, and also you've got a fear of prejudice and discrimination against your sexuality that may interfere with the care that you receive. So, it's important we do engage people honestly in that discussion.

[372] **Dai Lloyd:** Ocê. Symudwn ni ymlaen. Jayne, y cwestiwn nesaf.

Dai Lloyd: Okay. We'll move on. Jayne, the next question.

[373] **Jayne Bryant:** Thank you. Suzanne, you mentioned memory clinics, so what more do you think—? What do you see as the role of primary care in identifying people with dementia?

[374] **Dr Wood:** I see the role of primary care as being absolutely critical in identifying cases of dementia. Locally, we've actually commenced GP diagnostic clinics, funded through intermediate care fund moneys, to ensure that GPs are more skilled up and aware of dementia and they can make the

diagnosis, with the supervision of the memory team, following the consultation, to ensure that, using the Addenbrooke's cognitive examination III diagnostic tool, they can make a good and proper diagnosis, and there shouldn't be any misdiagnosis, or anything like that, in that instance.

[375] **Ms Slater:** Just to add to that as well, I think it's important to understand in the strategy what's meant by 'a competent clinician' as well, in terms of making a diagnosis, because that could be within the memory clinic, it could be primary care, GP services, but could that be others as well? Could that be a competent clinician who is also a mental health nurse, for example? So, we just need to, I think, think that through a little bit more so that we can perhaps expand our experienced clinicians to provide that service, too.

[376] **Mr Johnson:** I'm not convinced that the primary care setting is the correct setting in which to diagnose people with dementia. I don't think that the GPs have the time that's needed to conduct those sorts of assessments, and I don't necessarily feel that, actually, the skills and knowledge are there. I've had a lot of discussions with people who've felt quite dismissed by their GPs and, perhaps, didn't understand the issues. I have a family member who has dementia, and he was undergoing some psychotic symptoms at home, and the GP suggested that he needs to behave for his wife. Now that does show an alarming level of ignorance, I think, around the condition itself and it doesn't help anybody.

[377] I think, to improve access to memory clinics, we could open that up and say, 'Well, why is it that, at the moment, in some health boards, it is only accessible through GP or consultant referrals?' I think, if we're going to develop the workforce in line with the 'Good Work' framework, we're going to have more skilled individuals who can identify the early signs. And some professions are very, very good at identifying those early, subtle signs, but they're not necessarily GPs.

[378] **Jayne Bryant:** That was going to be next question, really, because we've had evidence from some other organisations saying that GPs may be reluctant to diagnose dementia because of the lack of support services out there, but you think it might be knowledge and skill as well as—

[379] **Mr Johnson:** Yes. I think, professionally, I couldn't disagree with that more; and personally I couldn't disagree with it more. I saw the evidence that was given, and one of the suggestions was around, 'Well, this person just has a little bit of anxiety and memory loss'. That could be quite a significant,

worrying factor, and particularly worrying, I think, in males, for example, where the fear of becoming a burden could lead to suicidal ideation—becoming a burden. So, no, I just don't agree with that at all; I think we need to take it very seriously and, perhaps the services will develop once we know the need. But I think we need to get as early a diagnosis as possible, absolutely.

[380] **Dai Lloyd**: Okay, turning to diagnosis rates, then, Caroline.

[381] **Caroline Jones**: Diolch, Chair. Good afternoon. The draft strategy sets a target for increasing the diagnosis of dementia by 3 per cent per annum. Can I ask your view on this, and also on the issues surrounding the collection and collation of data of diagnosis, regarding transparency and frequency of the collection of data?

13:15

[382] **Dr Wood**: I'm happy to take that question. So, I think 3 per cent is quite an ambitious target for per annum increase because, in Cardiff and Vale for example, I know, year on year, using the Alzheimer's Society figures for dementia diagnosis, its increase is between 1 and 2 per cent per annum. So, of course, it's great to be ambitious and to continue to have aspiration, but I think more resource would be required to ensure you get a timely diagnosis within certain areas.

[383] **Caroline Jones**: That's valuable, thank you. Anyone else?

[384] **Mr Johnson**: I think it's important to ensure that it's a robust system of diagnosis and done in a proper fashion, like we just said with the issue around GPs diagnosing. I think it needs to be managed carefully to ensure that we're not getting a lot of false positive diagnoses, because that can be equally as damaging, if not more so. I think it's ambitious, and I would echo what my colleagues are saying.

[385] **Caroline Jones**: What about the collection of data then, and the collation of it so that we've got an audit trail?

[386] **Mr Johnson**: I do think health boards should be doing that. I think we should be collecting that data and scrutinising data in terms of the numbers of admissions into the acute setting. Do we really know what those numbers are? I'm not convinced we do at the minute.

[387] **Ms Slater**: I think just one other thing to add is that the strategy mentions presumptive or working diagnoses, and I think, probably, that's quite helpful as well for people who are not ready to receive a diagnosis yet, or that it would be helpful in terms of meeting their needs that we begin to understand their presentations. So, I think that's helpful.

[388] **Caroline Jones**: Okay. Leading on to my next question, what is your view on the proposed waiting time targets of 28 days for the first assessment and 12 weeks for a working and preliminary diagnosis?

[389] **Dr Wood**: Presently, in Cardiff and Vale, the waiting time is 17 weeks for a new patient appointment at the memory clinic. I would certainly advocate for the four-week target, because it does mean that people get that timely diagnosis. Clearly, more resource is required to ensure that the capacity of a memory clinic is expanded in order to deliver on that target in the future.

[390] **Caroline Jones**: Okay.

[391] **Ms Slater**: I would agree. It's about increasing our resources so that memory clinics are more accessible.

[392] **Mr Johnson**: I definitely agree with that. I'd also echo what Dr Aziz—the evidence he gave last Wednesday I think, where he was talking around that subject. I think it's a very tight timescale, and it doesn't necessarily allow for investigations to take place within those timescales, as well.

[393] **Caroline Jones**: Okay, thank you very much.

[394] **Dai Lloyd**: Angela.

[395] **Angela Burns**: I just wondered if I could press you slightly on the target time—the 3 per cent. Is your view that the 3 per cent is ambitious enough because of a recognition of where we are in terms of resources, or would you feel that if we had more resources going into dementia diagnosis, dementia support and all the aftercare, that we'd be able to up that? Is it because we don't have enough people? Because we're quite far behind on being able to diagnose people, full stop, with dementia. So, is it purely that we don't have enough people, we don't have enough money, or is it something else that makes you think that 3 per cent is the credible target?

[396] **Dr Wood:** I think it does come down to resources at the end of the day. I think, with further resource, we could be more ambitious with the target, looking into the future. So, as you're aware, it's the complete pathway that needs to have resource added to it. So, it starts with having a dementia-friendly community, people being able to recognise that perhaps they may have a dementia or cognitive impairment in the first instance, then going to their GP, who need to have the skills and knowledge and education to be able to then refer appropriately on to the memory team, which needs to have the capacity to deliver on that diagnosis, and then they have to have it registered back then to the GP practice to add to the statistics, as such. So, it's the whole pathway that needs to be seamless and timely in order to deliver on an increased target.

[397] **Angela Burns:** If the GP isn't the gateway—you were suggesting that other people might be the gateway—what kind of other people would they be?

[398] **Mr Johnson:** Physiotherapists, occupational therapists, speech and language therapists, nurses—

[399] **Angela Burns:** So, other medical professionals.

[400] **Mr Johnson:** Yes. So, I think the education and training of the workforce is key, because the strategy talks about case finding and the early signs can be very subtle. So, it's having people who are able to identify and refer on. There shouldn't be any barriers to referral in my view, and I think there are at the minute.

[401] **Angela Burns:** Yes. Thank you.

[402] **Dai Lloyd:** Ocê. Yn nesaf, **Dai Lloyd:** Okay. Dawn is next. Dawn.

[403] **Dawn Bowden:** Thank you, Chair. The strategy is very much focused on trying to keep patients with dementia at home as long as possible, and I think that's a direction everybody seems to agree with. The confederation's evidence to us is suggesting that that's likely to mean that we've got to have a kind of realignment of the existing resources, and it talks about supporting new models of care and possibly a regional integrated strategy and all these buzz phrases that seem to be used at the moment. But, from your point of

view, what is needed, do you think, to develop those kinds of integrated packages that will help dementia patients stay at home for longer and what would be needed to support that?

[404] **Mr Johnson**: That's a massive question. Yes, it's very difficult to give an answer to that in a few lines, isn't it? I think it's so multifaceted, ranging from our housing stock, you know, the ability to adapt housing and have lifetime housing—I mean, that's one element of it. I think it's supporting the families and carers within that home setting; it's about trying to avoid what we know—we know that acute admissions to hospitals are dangerous for people with dementia. So, it's about helping to, not delay it, but manage that, and move away from a crisis-management system—that's what we have at the minute. So, I think we need stronger community teams. Again, it's going to come back to a lot of education and training. If you can teach the skills to avoid that admission or deal with those problems, then we're all in it together.

[405] **Dawn Bowden**: Okay, I'll ask the others if they've got a view on that as well, but can I take it from that that you recognise the importance of dementia support workers and the need for the way in which dementia support workers are utilised to be more consistent across the board?

[406] **Mr Johnson**: I think we need to accept that, as a society, again, this is one of the biggest health and social care challenges that we're going to face and finally we're waking up to that. I think this isn't just about dementia support workers. I think if we can train our workforce up to be competent in dementia skills—it's not rocket science—

[407] **Dawn Bowden**: So it's the whole workforce you're talking about.

[408] **Mr Johnson**: Yes. Well, if we adopt the 'Good Work' framework, that's what I'm saying. Actually, that document has a lot more descriptors and direction in it than perhaps the strategy denotes around certain areas. So, I think if we do that—because two dementia support workers within a GP hub, covering a certain area, I just think they're going to be sinking. They need that support.

[409] **Dr Wood**: I couldn't agree more. I think integrated models of care are essential in this field because of the package of care that's needed to wrap around the person with dementia and their loved ones and carers. So, already, community mental health teams locally are integrated, but it's trying

to make the whole pathway more integrated and also aligned with third sector organisations, such as the Alzheimer's Society. On the dementia support workers issue, locally there are three dementia support workers and they have the capacity to see only the newly diagnosed currently. So, in order to enhance the support after a diagnosis, I do believe there need to be more dementia support workers or their equivalents to follow up their care right to the end of their journey.

[410] **Dawn Bowden**: So, it's not just the consistency, it's the number of them as well.

[411] **Dr Wood**: Absolutely. The capacity to deliver on their care.

[412] **Ms Slater**: Indeed, I would just echo what my colleagues have said. It is about making sure that all the workforce are trained and we're thinking about occupational therapists and social workers, physiotherapists and everybody, really, who's available for people with dementia who are in the community. It is about developing those integrated teams that families can call upon to support them at home. As I said, we are looking at different roles, as well as the support workers, so that we can provide that additional support and assistance, but it will take some time to build up that critical mass, I think—

[413] **Dawn Bowden**: A dementia-friendly workforce.

[414] **Ms Slater**: Exactly: a dementia-friendly workforce. Absolutely.

[415] **Mr Johnson**: Can I just make one more point? I think the medical model is something that absolutely does not work within dementia care.

[416] **Dawn Bowden**: What do you mean by that?

[417] **Mr Johnson**: The medical model, so, dealing with the signs and symptoms rather than looking at the whole person, rather than looking at environment, their support network—

[418] **Dawn Bowden**: So, diagnosis is one thing, but then it's—

[419] **Mr Johnson**: Yes. I think when we're looking at that, we need to move away from a medical model to more of that person-centred approach, because actually providing the services that person needs may cost us a lot

less than giving people what we think they need. I do believe that there are other professions that are very willing to step up and take those roles to co-ordinate and manage those teams. I think we need to look at the person rather than the profession and move away from psychiatrist-led teams, if there are other people who are more suited to that role and that service.

[420] **Dr Wood**: If I could add a further point? Locally, we've conducted a dementia-needs assessment, which will feed into our local dementia strategy, and one of the top things that was noted was that kindness and compassion was the thing that service users wanted to see and feel more of in their day-to-day dealings with health and social care and the third sector. So, it really is about that person-centred model that's required. I concur with my colleagues about the 'Good Work' framework. It's an excellent framework. It looks at informed, skilled and influencer levels, so it goes right across the pathway. It really is a good guide for influencing the workforce development going forward.

[421] **Ms Slater**: Can I just add one other thing that you reminded me of? It isn't about—well, it is about helping people to have their needs met, living in the community, but it is all about trying to live as normal a life as possible. I was talking to somebody the other day who is a person who had dementia diagnosed at quite a young age. What he wanted was the opportunity to go to a rugby match or to go down the pub with somebody, not necessarily to go to a craft class, but to have the opportunity to do things that other people do and he sometimes needs support to do, to have someone to go with him who shared those interests. It's about what we can do in the community to make those things happen.

[422] **Dawn Bowden**: Sure. That makes sense, okay. Thank you, Chair.

[423] **Dai Lloyd**: Yn ôl i'r strategaeth ddrafft. Julie, mae'r cwestiwn nesaf gyda ti.

Dai Lloyd: Back to the draft strategy. Julie, you have the next question

[424] **Julie Morgan**: Yes, I was going to ask you about the role of community mental health teams, but obviously you've covered that. Is there anything more that you'd like to say about that?

[425] **Mr Johnson**: Yes, I personally feel and I professionally feel that that's not necessarily the right place to turn to for specialist care and support because, again, going back to that 'Good Work' document, if we are going to

train up our workforces to that level, we have other community teams as well that should be well placed to provide that advice and support. I think there is a misconception that mental health teams have the specialist skills to deal with dementia care, and I'm sure that is the case in silos—I've no doubt of that at all—but I would say that's quite a sweeping view.

[426] **Dr Wood**: I concur in a way that dementia really is everybody's business, so it's really about skilling up the workforce to be able to manage people better in the surroundings they would like to be cared for. So, it's really about getting the skill levels up, across the board.

[427] **Julie Morgan**: You've mentioned some of the things that are important for people with dementia. You mentioned going to the football match. Do you think there should be the inclusion of a key action in the draft strategy on reablement that would include access to reablement services that would include that sort of initiative?

[428] **Ms Slater**: Absolutely, I would agree with that. We've talked about loneliness a lot in respect of older people just recently, but we need to think about that particularly for people with dementia who may be perhaps more lonely than others. So, what can we do to help people to live stimulating and active lives as well as they're able to? So, yes, we do need to think about how we bring that into this. That needs to be part of the integrated care pathway.

[429] **Dr Wood**: I couldn't agree more. Reablement is absolutely critical in the process. I think being able to maintain hobbies and friendships and relationships with people is absolutely critical to living the best life that you can do. For example, I know some agencies have put on Singing for the Brain, which people do love if they like to have a singalong, and other hobbies that they'd like to keep going with, essentially. So, reablement is absolutely critical.

[430] **Mr Johnson**: It's not just reablement, but enabling as well. 'Reabling' suggests getting back to something; 'enabling' means making the most of what we've got.

[431] **Dai Lloyd**: Gan symud ymlaen i'r rhan yna o'r strategaeth ddrafft sydd yn ymwneud â gofal dementia yn ein hysbytai ni, mae gan Rhun gwestiynau.

Dai Lloyd: Moving on to the part of the draft strategy that relates to dementia care in our hospitals, and Rhun has questions.

[432] **Rhun ap Iorwerth:** Prynhawn da i chi. Gan edrych ar beth sy'n digwydd pan fydd pobl hŷn, a hefyd pobl sydd â diagnosis dementia yn barod, yn cyrraedd yr ysbyty, mae'r strategaeth yn sôn am sgrinio ar gyfer dementia a deliriwm pan fydd pobl hŷn yn cael eu 'admit-io' i ysbyty. Mae'r conffederasiwn, er enghraifft, yn sôn am y pwysigrwydd o gael y sgrinio hefyd. Beth ydy'ch barn chi ar hynny?

Rhun ap Iorwerth: Good afternoon. Looking at what happens when older people, and people who already have a diagnosis of dementia, get to hospital, the strategy talks about screening for dementia and delirium when older people are admitted to hospital. The confederation, for example, also talks about the importance of having that screening. What is your feeling on that?

13:30

[433] **Ms Slater:** Absolutely, I would agree with that. In Aneurin Bevan university health board we're in the process of developing a cognitive impairment pathway. Because, as I'm sure you're aware, people can come in to hospital—older people—and they're confused, and it may be because they're suffering from an infection and we need to be quite clear about what that confusion is, and to treat people appropriately. So, we're developing this cognitive impairment pathway to support clinicians in making that assessment and diagnosis, so that people can be treated properly.

[434] I think there's a second part to your question as well, I suppose, in terms of screening. I think, probably, I would go back to the public health message about making every contact count. So, when we meet with people in a healthcare setting, whether that's within the community, in primary care, or within a hospital, then we do need to make that contact count in terms of understanding not just their illness if they're presenting with one, but also their health needs. That may include undertaking some screening for dementia—early screening—if that seems to be appropriate. So, it is using all of those opportunities to support early diagnosis, but also to make sure that people are treated appropriately.

[435] **Dr Wood:** I couldn't agree more. So, case finding is obviously quite different from population screening, which I wouldn't advocate for. But case finding, in particular settings where you've got high-risk groups is critical to the care pathway. So, I would advocate for that, absolutely. And from a public health position, I would definitely advocate the 'making every contact count'

messages as well, and ensuring that people have those healthy lifestyles to prevent and delay the onset of cognitive impairment and dementia.

[436] **Rhun ap Iorwerth:** What about when a dementia patient finds themselves admitted to an acute hospital setting, and the need to ensure that both their mental and physical well-being are taken care of and are recognised by that hospital? What needs to change?

[437] **Dr Wood:** I think, speaking from a local context, we do use the Butterfly scheme to identify people who have a diagnosis of dementia or a delirium. Underneath that you've got the Research in Ageing and Cognitive Health team tool, which is really a person-centred tool to ensure that the person with dementia, when they go from one ward—say from the emergency unit, to one ward to another ward—that their paperwork follows them and people get to understand that person much more. Also, it encourages people to think about the triggers that may cause behaviour that challenges, so they're going to be able to better manage in that setting. So, I think having that broader scale approach, using either the Butterfly scheme or 'This is me', or an equivalent tool that's person centred, in that environment, is essential.

[438] **Mr Johnson:** I think there's a big gap at the minute between looking after someone's mental health in terms of dementia and their physical health. I think what people tend to see is the dementia, and they don't see beyond that and see what might be contributing to the signs and symptoms of dementia. I have a very strong belief that dementia is not a mental health condition, and so it should not be treated as such. This is a physical health condition that manifests itself here in these signs and symptoms. In terms of developing the workforce and making sure that graduates are being trained at the right level before they come out of universities, not doing a project that involves three hours' work, but, 'This is going to be your bread and butter, this is what you're going to be doing on a daily basis, so let's skill you up now and that way then, in the long term, that will help.' It will help save time in terms of training costs. But, dementia is not a mental health condition and there's a big gap at the minute. Physical nurses, I think, believe that it's a mental health condition—'I don't know, I'm not trained'—and mental health nurses tend to not, perhaps, look at the physical aspects of care. Again, a very sweeping statement. In silos, I'm sure that's not the case, but in my experience.

[439] **Rhun ap Iorwerth:** Okay. Just back to Dr Wood, briefly, you mentioned

examples of good practice and what should be happening. What is your impression of whether good practice is widespread?

[440] **Dr Wood:** I can only talk about the local context, really. Certainly, locally, we'd like to advocate to have that more widespread than it currently is. But, again, it's a kind of resource issue, because it does require training and development to make sure it's applied appropriately because it's an opt-in scheme for the Butterfly scheme. So, it's important that the staff are using it appropriately and that it follows the patient through their journey in the hospital setting. So, I think it is a resource and training issue as well.

[441] **Rhun ap Iorwerth:** Are they real barriers? Are you unable to do things because of resource issues?

[442] **Dr Wood:** It can be a real barrier. But, also, it's a cultural change as well. People have to recognise the importance of seeing that someone may have dementia or a cognitive impairment to be able to manage them appropriately in that setting.

[443] **Mr Johnson:** I think there are big resource problems, like environment, and hostile environments—that's one of the biggest factors that I believe feeds into disorientation, confusion, and can also cause delirium as well. I think there needs to be investment in that. We're not talking about millions of pounds. We're talking about changing the colour of paint from magnolia to something that's a bit more soothing and natural, perhaps. You know, it's about appropriate signage. These things can help, and they're not massive investment issues. I think there are areas of good practice that can be taken and used as a model and replicated elsewhere. We had a ward in Tonna hospital, where one of the occupational therapists went in and did a project around environment, training up the staff and looking at meaningful activities. All the negative markers that the hospital would've looked at, in terms of violence, aggression, sickness absence and stress levels, all came down. It is possible. It requires a small investment, but we're not talking millions and millions of pounds.

[444] **Dr Wood:** I agree, and what might be useful for strategy: there's a King's Fund toolkit that looks at dementia-friendly environments, both in the ward setting and generically in the hospital setting, that could aid people to progress that even further. As Nick said, it talks about things such as lighting, contrasting colours, wayfinding signage—that kind of thing that ensures that people, from the front door, will have a dementia-friendly

environment.

[445] **Dai Lloyd**: Lynne, you've got the next set of questions.

[446] **Lynne Neagle**: I wanted to ask about older people's mental health wards. One of the things that the predecessor committee looked at when we scrutinised the Nurse Staffing Levels (Wales) Bill was whether the Bill should be extended to other settings, and I am personally very keen to see it extended to older people's mental health wards. Would you see that as a priority?

[447] **Ms Slater**: I think the number of staff and the skill mix of staff is clearly crucial wherever patients are cared for within a residential setting, particularly a hospital setting, and clearly we need to have that right skill mix to meet the needs of patients. My understanding is that, yes, that's what we will be looking at. As you know, in terms of the Nurse Staffing Levels (Wales) Act 2016, we're looking at acute medical and surgical wards first, but we're rapidly developing models to think about community nursing but also mental health nursing, particularly in older adult mental health units.

[448] **Lynne Neagle**: Thanks.

[449] **Mr Johnson**: In my role, I do a lot of training of nurses, physios and OTs, and the consistent factor that comes back amongst nurses is the lack of appropriate staffing on the wards. Now, some of that is about education as well, and like they were saying, the right skill mix, because if you've got two individuals who are very skilled, it's a lot easier, so it's finding that right level there. We have massive problems recruiting nurses at the minute, and applications have fallen by, I think, a quarter because we're losing bursaries, and that's not going to be good news. So, I think we do need to think about that.

[450] **Lynne Neagle**: Okay, thank you.

[451] **Dai Lloyd**: Moving on, because we've got four questions and seven minutes.

[452] **Lynne Neagle**: Antipsychotics—we know that they are being inappropriately prescribed. You've said that you think the strategy should go further in that area, but we also know that there aren't the alternatives. How do you propose that the Welsh Government tackles that, because there isn't

the access to talking treatments and the staff issues are difficult and what have you?

[453] **Dr Wood:** I think in certain settings such as care homes, which I think the strategy does mention in particular for the antipsychotic use, the non-pharmacological methods do need to be embraced and enhanced and go a bit further to ensure that that care is appropriately managed without the use of medication. That can also be applied in the hospital setting as well, but really I think what does happen—and there's recognition locally—is that sometimes in the hospital environment, an antipsychotic is started due to behaviour that challenges, and then it may not be stopped on discharge. So, locally, we've implemented guidance that ensures that that now should not be happening. So, in a way, you're turning off the tap, if you like, of the antipsychotic and then going on into the community.

[454] **Mr Johnson:** We've developed an audit tool to ensure that antipsychotic use is being reviewed regularly, but, yes, I agree—I think the non-pharmacological options that are available are well-evidenced. There are reams and reams of evidence around meaningful activities and the reduction of psychotic behaviours, so it's a question of, 'Why aren't we putting this into practice?' Again, I think it comes back to education and training, ultimately, as well.

[455] **Lynne Neagle:** Okay. And just on palliative care, you've suggested that the strategy could do more on that, in relation to drawing a distinction between palliative and end-of-life care—what would you like to see included then?

[456] **Dr Wood:** I think that the recognition of advanced care planning, when a person has capacity to make those right decisions for their end-of-life care, is absolutely essential. So, it starts with being diagnosed, and from that stage onwards, because it is a chronic and progressive illness, people would have insight at that stage to work out what they would like for their end-of-life care. As described in the confederation's response, the palliation phase essentially starts almost from diagnosis, but end of life is actually towards those last days. So, planning for that eventuality is really essential, and I'd like to see that enhanced more in the strategy as well.

[457] **Mr Johnson:** I think clear definitions of what constitutes palliative care, end-of-life care and palliative care at the end of life—those are three separate things. Actually, the 'Good Work' framework describes them in far

greater detail and better detail. I think one of the key things is that we're not giving carers, families and the people themselves a clear indication that it is a terminal condition—'This is a terminal condition, let's accept that.' How we deliver that news—it needs to be done sensitively, of course, but we must accept it. The survival rate for Alzheimer's is 0 per cent, so that's the fact.

[458] **Ms Slater**: I'd like to add to that that palliative care can be needed for a number of years. I think that's the other thing to say.

[459] **Mr Johnson**: And that's my point. End of life—is that the last two weeks? Is it the last four weeks? That's what we need the definition for, but palliative care could be years.

[460] **Dai Lloyd.** Okay. The last couple of questions—Angela, you've got five minutes.

[461] **Angela Burns**: The 3 per cent target—in order to achieve that, I wondered what your views were on not just the resources, but how, if we're going to deliver that, we can measure along the way the progress that we're making. What would be the best measurements to put in place as to how close we are getting to achieving those outcomes that we're looking for? When I look through the draft dementia plan, I'm not seeing outcome monitoring featuring very highly, and I wondered what outcome monitoring for knowing what success looks like and whether you're achieving it in your particular areas—what do you use?

[462] **Mr Johnson**: Is that purely on diagnosis rates, or just services as a whole?

[463] **Angela Burns**: Diagnosis rates, because that 3 per cent is tangible, so how do you measure that, and then all of the services—are we actually providing the step change in service that we say that we want to?

[464] **Mr Johnson**: I think we need to be asking service users that question, and we need to be asking people living with dementia that question. I'd be interested to note—will you be talking to people with dementia as part of this committee? This is about them, ultimately—well, it's about all of us, but we need to involve them in that question. In terms of the diagnosis rate, I'd say that Dr Wood could probably—

[465] **Angela Burns**: That's about qualitative responses, isn't it?

[466] **Mr Johnson**: Yes.

[467] **Angela Burns**: I'm just wondering whether, when you're actually trying to scrutinise the effectiveness of a policy and you're chasing the money through the system, this money is actually delivering the outcome that you hope it would. You also need some quantitative stuff. I absolutely take on board your point that unless we talk to the carers and the people with dementia, we won't know the quality of it, but we also need quantitative measures. I wondered whether you thought that there were sufficient quantitative measures built into the delivery plans.

[468] **Ms Slater**: We're trying to do that in Gwent. We're trying to develop an outcome measures action plan. So, we have a dementia board, and that's a multi-agency board with carer representatives. We're hoping to have somebody with dementia also being part of that board. So, we've developed now a framework that takes account of the skills of staff, training about dementia-friendly communities—all of those things that we want to put in place that we know—. They're proxy measures, really. They're not outcome measures—they're proxy measures. But if we've got proxy measures in place, if we know that the five local authority areas in Gwent are dementia-friendly local authorities, if we know that our hospitals are working towards dementia-friendly status, if we know that our staff are trained and skilled, and we're hoping that we'll have 75 per cent in Aneurin Bevan by March, then that gives us some confidence that we're developing better outcomes for people.

[469] **Dr Wood**: If I could add something: locally within Cardiff and Vale, we do have a dementia three-year plan, which is coming to its end in March of this year. We're going to develop a further strategy after that. But throughout the lifetime of the plan, we've had a monitoring and evaluation sub-group, which tracks performance measures over time. It's measured on a quarterly basis, so that we can see whether we're going in the right direction. They're flagged using a red, amber or green status so we can see the direction of travel and whether we need to actually take action in certain areas. So, the domains that were used were actually taken from the Welsh Government dementia vision document that was produced I think in 2009-10.

13:45

[470] So, it's those four domains. We track the indicators of outcomes and

proxy measures aligned to those locally, so we do actually monitor dementia diagnosis levels, but they're only currently being able to be extracted on an annual basis, as I'm sure you're aware. We would welcome more frequent data on that but obviously, again, they need to be resourced. As I said, we're monitoring the waiting time for memory clinic and the number of dementia friends, and we're proud to say that we've skilled up over 7,000 people locally as dementia friends. So, we're really starting to get traction on the dementia-friendly communities initiative, but there are other markers as well that we're using and utilising to ensure that we are monitoring progress. So, if something like that were to be taken nationally, that would be great, because we could then have the benchmarking data to use across the seven health boards and the 22 local authorities across Wales.

[471] **Angela Burns**: Thank you.

[472] **Dai Lloyd**: Thank you. Spot on time, Angela.

[473] Diolch yn fawr. A diolch yn fawr am eich tystiolaeth y prynhawn yma. Diolch yn fawr am ateb y cwestiynau mewn ffordd mor raenus ac mor aeddfed. Gallaf bellach gyhoeddi y byddwn yn anfon trawsgrifiad o'r cyfarfod yma i chi er mwyn i chi gael ei wirio er mwyn gwneud yn siŵr bod pethau yn ffeithiol gywir. Felly, gyda hynny o ragymadrodd, gallaf ddatgan bod y darn yma o'r sesiwn ar ben. Felly, diolch yn fawr iawn i chi gyd. Ac i'm cyd-Aelodau, awn i egwyl nawr a dod yn ôl am 2 o'r gloch.

Thank you very much. And thank you very much for your evidence this afternoon. Thank you for answering the questions in such a polished and mature fashion. I can now let you know that we will be sending you a transcript of the meeting today so that you can check it for factual accuracy. Therefore, with that, I can state that this part of the session is now closing. Thank you very much for coming. And to my fellow Members, we will now go into a break and then come back at 2 o'clock.

Gohiriwyd y cyfarfod rhwng 13:46 ac 13:58.
The meeting adjourned between 13:46 and 13:58.

Ymchwiliad i Strategaeth Genedlaethol Ddrafft Llywodraeth Cymru ar Ddementia: Sesiwn Dystiolaeth 6—Cymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol
Inquiry into the Welsh Government's Draft National Dementia Strategy: Evidence Session 6—Welsh Local Government Association and the Association of Directors of Social Services

[474] **Dai Lloyd:** Croeso i sesiwn ddiweddaraf y Pwyllgor Iechyd, Gofal Cymdeithasol a Chwaraeon yma yn y Cynulliad. Rydym wedi cyrraedd, rŵan, eitem 7 yn ystod ein dydd o gyfarfod. Eitem 7 ydy parhad efo'n hymchwiliad i strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia. Hwn ydy sesiwn dystiolaeth Rhif 6, ac o'n blaenau mae Cymdeithas Llywodraeth Leol Cymru a Chymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol. Hwn ydy'r sesiwn dystiolaeth olaf yn ein hymchwiliad byr ni i strategaeth genedlaethol ddrafft Llywodraeth Cymru ar ddementia. Mae yna gyfarfodydd eraill i ddilyn ar yr un thema, ond yn sylfaenol gogyfer â'r prynhawn yma, rydym wedi derbyn tystiolaeth ysgrifenedig gan ein tystion, sydd o'n blaenau ni, ac wrth gwrs, rydym ni ar fin mynd i mewn i'r drafodaeth ar lafar. Mae yna broblem efo'r cyfarpar cyfieithu, efallai. A ydy'n gweithio rŵan?

Dai Lloyd: Welcome to the latest session of the Health, Social Care and Sport Committee here at the Assembly. We have now reached item 7 during today's meeting, and that item is a continuation of our inquiry into the Welsh Government's draft national dementia strategy. This is evidence session No. 6, and before us we have the Welsh Local Government Association and the Association of Directors of Social Services. This is the final evidence session in our short inquiry into the Welsh Government's draft national dementia strategy. There are other meetings to follow on the same topic, but primarily in relation to this afternoon, we have received written evidence from our witnesses, who are before us, and we are about to discuss this issue. Sorry, I think we have a problem with the equipment. Is it working now?

14:00

[475] **Mr Ayling:** Sorry, I lost the English translation for a minute. So I just missed the last 20 seconds of what you said.

[476] **Dai Lloyd:** Worry not. We're always complaining about the lack of

powers in this place. [*Laughter*.]

[477] **Mr Ayling:** Okay.

[478] **Dai Lloyd:** We're about to lose some more, but that's a separate issue. We'll muddle through.

[479] Felly, o'n blaenau ni—ac rwy'n falch o'u croesawu—Naomi Alleyne, cyfarwyddwr gwasanaethau cymdeithasol a thai, Cymdeithas Llywodraeth Leol Cymru, Neil Ayling, llywydd Cymdeithas Cyfarwyddwyr Gwasanaethau Cymdeithasol Cymru a phrif swyddog gwasanaethau cymdeithasol Cyngor Sir y Fflint, a hefyd Julie Boothroyd, pennaeth gwasanaethau oedolion Cyngor Sir Fynwy—gyda dau begwn Cymru wedi'u cynrychioli, felly. Fel rwy'n dweud, rydym ni wedi darllen eich papurau gerbron, ac awn yn syth i mewn i gwestiynau ar y strategaeth ddrafft. Felly, Angela sydd i ddechrau.

So, before us we have—and I'm very glad to welcome—Naomi Alleyne, director of social services and housing, the Welsh Local Government Association, Neil Ayling, chief officer of social services at Flintshire and president of the Association of Directors of Social Services Cymru, and also Julie Boothroyd, head of adult services at Monmouthshire. So we have two polar, separate ends of Wales represented here. So, as I've said, we've read the papers before us and we'll go straight into questions, if we may, on the draft strategy. Angela is going to start.

[480] **Angela Burns:** Thank you. Good afternoon. Thank you very much indeed for your evidence. In your paper, you refer to the development of a strategic action plan as

[481] 'a golden opportunity to set out our aspirations for what the NHS, local authorities and our partners',

[482] stakeholders, could do, going forward. What contribution do you think this draft strategy plan might make to the integration of health, social services, or social care and social services, and third sector organisations?

[483] **Mr Ayling:** Thank you for the question, and thank you, Chair, for the introduction. We're very pleased, as a professional organisation, to be asked to give evidence. I think a key issue in terms of integration and partnership working between health and local authorities and the wider communities is

how we work together to actually improve outcomes for people in relation to people with dementia. Clearly, one of the key areas we've covered in our evidence is what we all can do, as partners, to make sure that the outcome for the individual is as positive as it can be through that joint working. Quite clearly, some of the key issues that the local authority needs to get right—and social services as part of that local authority—is how we work with health to make issues such as early diagnosis work as sensitively as possible for people, how we can actually seek to remove some of the stigma in relation to dementia to actually ensure that it is something that people don't need to see as something that they should be, in any way, ashamed of. I think we've made great strides over the last two years with that. I know, from just hearing the end of the evidence in the previous session, the actual approaches within local communities to actually develop dementia-friendly approaches. I know Julie has experience in her authority of actually seeking to get memory clinics working in a more effective way. I think those are the opportunities that we can do jointly with health colleagues. I think all of us have this particular group of our community—both people who have dementia, their carers and their families—as a key priority that we need to respond to. So, in a sense, those are some of the reasons why we had said that the actual strategy is a golden opportunity for the service. Certainly, the aims, aspirations and visions espoused by the strategy are ones that we would support.

[484] **Angela Burns**: Given that integration between the two sectors is something that's talked about a lot, do you think that, in the current climate, this is deliverable, or do you think that we actually need to try to use this to lever in a lot more collaboration? Are we very far away from that goal?

[485] **Mr Ayling**: I think there is very effective collaboration in authority areas with health board colleagues on this agenda. I have many examples from my authority of where there's been really rapid progress in this. I actually think that all partners need to be together on this journey in relation to development. I wouldn't personally think we need to bring about another systematic integration process to achieve benefit. I think what's important are the outcomes for individuals and whether that working is joined on the ground to actually ensure that people don't fall through the net.

[486] **Ms Boothroyd**: Can I just add to that, really? I agree with Neil, largely, but there was a little bit in terms of—. I think there is a cultural difference between health and social care, which everybody will be aware of. Actually, sometimes, bringing this together can be quite difficult. I suppose that I can

illustrate that with an example that Neil mentioned, which is moving memory assessment services out of a psychiatrist hospital into a community setting. We had to use quite a lot of influence, I think it's fair to say, to persuade our health colleagues that this was the right thing to do. And it was very much about addressing the issue of stigma. It was actually quite a long, long way from anywhere, and people were very frightened and worried about going into a psychiatric hospital for that assessment. Actually moving that into a community facility with a community cafe, with other resources—third sector and support for carers around that—has, I think—. I think we've acted as a lever of change to the health authority locally to say, 'Actually, this looks better, feels better, and the outcomes are going to be a heck of a lot better, and are, for individuals'.

[487] So, I do agree, but I do think there is some shifting of cultures that does need to be done to achieve more, I think.

[488] **Angela Burns**: Thank you. Naomi.

[489] **Ms Alleyne**: Just quickly as well, I think the strategy is aiming to develop that pathway for people with dementia that looks at the interaction between health, social care, housing and other parts of the sector at different stages as well—so, having that pathway that people will understand. We often talk about seamless services, so it doesn't really matter which agency is delivering to the citizen but, actually, that they get that comprehensive approach there. There's also reference within the strategy to the role of regional partnership boards, which, obviously, are made up of health and social care, under the Social Services and Well-being (Wales) Act 2014, but, obviously, possibly a role for public services boards where you bring in some other public sector partners to take that work forward. So, some of the structures are there so that that integration is happening. The strategy is very much around making sure that that integration happens on the ground in terms of—. And including carers, third sector, and independent sector within that. Again, I think the aim would be having those seamless services that actually meet the needs of individuals. So, it's a very broad aspiration; I think it's certainly one that we support, but there's a journey, if you like, for us to get there.

[490] **Angela Burns**: And if I was just to build on that commentary, one of the areas you really identify in your paper as there being very little reference to is housing, and you talk about the need for housing to link—you use that word 'link' quite effectively. Perhaps you could just highlight a little bit more

your concerns over the issue of housing within the draft dementia strategy.

[491] **Ms Alleyne:** There are very few references to housing within the strategy, but there's a lot of work ongoing across Wales, both at the strategic level, but also locally, in ensuring that, actually, housing is an integral part of that discussion, because, obviously, people are saying that their preference would be to remain in their homes. That means that we need to develop homes that will meet those specific needs, but also that can be adapted according to people's needs. There are opportunities out there, but I don't think they've been drawn out enough within the strategy. It's probably just one of those areas where you'd need to look at and strengthen what the contribution of housing can be, both from local authorities, but also from the housing associations as well.

[492] **Mr Ayling:** One specific area around supporting people with dementia is in relation to extra-care housing, which has been very successful in my authority, with two schemes that support people with needs across a spectrum, but including people with dementia as part of a community around extra care. We have two such schemes in Flintshire, and we're developing two more. One of the key issues I would raise with you is that having a sustainable funding way of actually making extra care develop and not actually stop at a certain level is a concern that some of us have. It's not the only issue around housing—far from it—but it's an example of a new, very popular and innovative way of provision that has been really successful at supporting people with dementia as part of the community.

[493] **Angela Burns:** Can I just very quickly, on the housing issue, just ask: have you seen any sort of spike in older people as they develop dementia who might be in either the private rented sector or private owned sector actually coming over and asking for not just help to make their homes more friendly for themselves, but actually saying they need to have a completely different kind of home and can you provide it?

[494] **Ms Alleyne:** I'm not aware of anything, unless—

[495] **Mr Ayling:** No. I think in some communities in north Wales, particularly Conwy, a very popular retirement community, there's been quite an influx of people of retirement age, and I'm sure it's the case in other authorities.

[496] **Ms Boothroyd:** Just from a—[*Inaudible.*]

[497] **Dai Lloyd:** [*Inaudible.*]

[498] **Ms Boothroyd:** I keep seeing you pressing it, and I think—

[499] **Mr Ayling:** I'll stop pressing it.

[500] **Ms Boothroyd:** What I can add to that is that some of the RSLs locally have been carrying out quite a bit of useful research in trying to forward plan what provision might be needed for the future, and the learnt wisdom was always that people needed different accommodation, but, actually, we were finding that people weren't taking up certain types of accommodation. So, they carried out some very interesting research that proved a different model was needed. I agree with the extra care approach, and that is something that we want, because we're trying to keep people in their own homes for as long as possible, whatever that home is. But this desire market was very much about people needing to be near things that they need to access, for transport or for facilities, but also having that was a little bit more than just perhaps an older person's bungalow, and wanting something that anybody might desire—a two-bed, nice, lifestyle-type property.

[501] So, actually, this RSL has taken a very different approach and said, 'We need to build and design very differently for the next 10/20 years, because, actually, there is a desire that's different that's coming up from the one that we've, perhaps, previously planned for.' So, I think there's some very interesting work that is looking at forward planning around that. It's just then trying to make that happen.

[502] **Angela Burns:** Thank you.

[503] **Dai Lloyd:** Ocê. Symud ymlaen i rannau eraill o'r strategaeth ddrafft, a Dawn yn gofyn cwestiynau nawr.

Dai Lloyd: We'll move on, then, to the other parts of the strategy. Dawn, please.

[504] **Dawn Bowden:** Thank you, Chair. A couple of areas I wanted just to explore with you—one is around the value of dementia support workers, and I know in your evidence you talk particularly about the social care workforce in general terms, and you talk about addressing the low pay issue, and that's an ongoing—. That's a work in progress, shall we say? But I just wanted to ask you, really, about the value of dementia support workers, as I said, whether you believe that the current level that we have available to provide support is sufficient, and, if not, where you think that needs to be pitched.

And then, obviously, the $64,000 question is: where is the money going to come from?

[505] **Mr Ayling:** Go on, have a go.

[506] **Ms Boothroyd:** I'd like to have a go at this one, just because I'm very passionate about this particular issue. I think it's fair to say, across local authorities and across health, we are facing a crisis in the workforce of social care, particularly at that front end. This winter has been particularly hard and is not getting any easier, and it's taking longer. I think there is a real issue around there not being a good enough image of what caring today is about and that people have an image—perhaps some of us may have that image; I don't, but some people might—which is that it is not very well paid, the terms and conditions aren't very good, and, actually, you're doing quite hard work spread across a big geography. Actually, the reality, when you talk to the front line and the workforce—it isn't like that at all. There are some wonderful stories; there are great things happening. But we're not managing to attract more people, and I think there's a real opportunity to give care a facelift and really promote it in a different way and create a structure around workforce development that values that front-line support.

[507] I'd just add, from a personal perspective from Monmouthshire—and I was saying to Neil earlier—we actually took some evidence from some front-line staff who were saying, 'I don't think we can do this anymore; it's too hard. We're being spread too thinly. We're wanting to do things that you might not think that we should be doing, but we are doing them anyway'—you know, taking people out and about, whereas it was very much task and time. We listened to them and said, 'Okay, what can we do differently?', and created a very different approach that has now been rolled out. That's a small example of how you can train, value, pay differently, and give different terms and conditions, to enable the workforce to feel like $1 million—those are their words, not mine. I do think we have a bit of a crisis, and we've got to address it if we want to manage care into the future and for people with dementia—I'm talking about the whole workforce, but, certainly, around people with dementia.

[508] **Mr Ayling:** Just to add to that just three things—and I completely support what Julie said—firstly, one of the really positive things in relation to the agenda around dementia is the growth of dementia cafes in my area. We've had seven that have developed in Flintshire, supported by local towns, and they are supported mainly and overwhelmingly by volunteers who are

people of the local community who are actually coming in to support their friends and their families in local communities.

14:15

[509] That's bringing some new groups of people into, potentially, the health and social care workforce. One example is young parents, young mothers. It's their first major exposure to that and it's potentially a way of getting into the health and social care workforce in the long term. So, I think, when we're talking about the dementia workforce, it is a very broad element.

[510] The second thing I wanted to say is, quite clearly, our care homes—our independent and local authority sector care homes—all need to be seen as part of that workforce. I was speaking to the chief inspector, Gillian Baranski, earlier today, who was saying—she obviously goes to see care homes—she went to a care home, a nursing home, and I think she said 47 people were there and all but three of them had dementia, so 44 out of 47. That is replicated throughout Wales. So, in a sense, we need to be thinking about that wider workforce and investing in that. Quite clearly, you would expect me to say there's an element of resources that's needed to pump-prime and invest that on a community basis, with our third sector partners as well as in hospital care.

[511] **Ms Alleyne**: I think the final point I would make is—. I think you asked about resources. I think, if I recall, they were looking for 32 support workers with an investment of £800,000 across Wales. I think it's probably a view that the third sector would be able to give, particularly around whether that's spread too thinly in terms of the roles that they undertake, because, looking at the strategy, it's not only around diagnosis, but advice and information in the broader sense, to help people come to terms with the diagnosis, to react to it and to start the preparations that are needed for how the illness will degenerate, probably, over time. So, there is investment in there. I think I tried to work out how much each of those would cost in terms of on costs, but it's making sure that some of those support workers are able to signpost to other forms of advice and information that will be there that people can take advantage of. One of the initiatives we've developed is Dewis, which is an online website. I've asked my colleagues to look at what information is available around access to dementia support services on Dewis and how we can develop that so there are clear opportunities for people to dip in and dip out of getting the information and signposting to services that they need as well. We'd certainly welcome the role that the support workers take in that

broader support for people following diagnosis.

[512] **Dawn Bowden:** I'm assuming you have less control over how that is developed in the private and independent sector compared to directly employed staff, services and so on. The point you were making, Julie, earlier on about the terms and conditions et cetera—again, that's something you can control from a local authority perspective, but there's no control over that in the independent and third sectors, and they're critical to the whole strategy. I'm not asking you to be able to respond to that because, in a sense, I'm not sure that you can, but I think we just need to put that out there in terms of the difficulty. Just on the issue of funding, I don't know whether you've seen the proposal from Age Cymru, who talk about having a national strategic approach to funding dementia to help the short-term funding difficulties. I'm not quite sure what they mean by that, but I think what they mean by that is everybody pooling the resources. Have you got any thoughts on that?

[513] **Mr Ayling:** I haven't seen that specific proposal, I must say, but I think we have to pool resources, virtually and in every way, to actually impact change in relation to this agenda. You mentioned the relative lack of control that we might have in relation to independent sector colleagues. Quite clearly, one of the areas we've taken forward is looking at culture change for their staff in relation to this, which takes some pump-priming in terms of training materials, in terms of awareness, and in terms of, particularly, projects to actually work with us. But, we can achieve a lot. One of the examples we've had in north Wales is we've worked in partnership with Bangor University, which is an acknowledged centre of expertise around dementia care, to actually encourage homes to come forward with projects in relation to improving the care of people with dementia in their homes. That was an incredibly affordable way of actually achieving quite a lot of good outcomes for people. There are issues in relation to the wider health and social care sector and the pressures in that are well canvassed and in a sense we probably can't go into that today. But, quite clearly, dementia is one of the main challenges around that. Again, I don't want to go on, but in local authorities in many ways we've sought to specialise our care for our in-house provision and actually work around dementia reablement services and maybe support specialist schemes such as extracare but we actually need that wider sector to work with us.

[514] **Ms Boothroyd:** If I could just add to that briefly in terms of—. I wouldn't want people to think that we don't have—the word 'control' feels a

bit funny but I know what you mean.

[515] **Dawn Bowden**: Influence.

[516] **Ms Boothroyd**: Yes, influence, that's the word. I think certainly the approach that we've taken, given that we've remodelled everything in-house like Neil is describing, is that we've gone on a journey with our market, with our providers, who are independent and private individual businesses, and actually brought them to the table and said 'How can we solve this problem?' Surprisingly, to us as well, they have the answers, which I knew they would have, but actually they're willing to contribute and co-operate together. So, actually, we've been able to make quite a lot of progress. I wouldn't want people thinking we don't have influence, because we do. It's about an approach to working together. The word co-production is the one we use.

[517] **Dawn Bowden**: You basically buy their services in, don't you? So, you are the customer. You've got a bit of control over that haven't you?

[518] **Ms Boothroyd**: Absolutely. But it's about how we solve this problem together, and that's proving to be very useful.

[519] **Mr Ayling**: There are various elements of that control. As well as the co-production, we also have contract monitoring staff that actually enforce those standards. So, there is a carrot and stick. But it's about working with partners on this agenda. Again, I don't want to—. We have engaged a lot more partners on this agenda than traditional ones—local communities, businesses, shops, town councils—and that has been really powerful in terms of taking forward a really positive change.

[520] **Dai Lloyd**: Mae amser yn carlamu ymlaen ac felly mae cwestiynau eraill i ddilyn. Julie Morgan sydd nesaf.

Dai Lloyd: Time is moving on and there are other questions to follow. Julie Morgan is next.

[521] **Julie Morgan**: I think you say in your evidence how important it is to have the person at the centre of the planning. What would opportunities do you think there are for the dementia sufferer to have a say on what the treatment should be or what that person needs? If you could say what opportunities there are now and whether you think the strategy should be doing more along those lines.

[522] **Ms Boothroyd**: Definitely more. We could always do more. I do think that the approach around the person is where we have to get to. Actually, often there has been a little bit too much 'doing to' people and not 'doing with' or enabling people. We've taken a very different approach, which is about actually having the person at the centre, who is in a sense—. We meet the person with dementia where they're at. The training programme certainly that we've used is about skilling our workforce up in a very deep way so that actually they do have the skills to be able to do that, and I think that's quite an important part. We've actually invested in a six-day programme for 350 staff, both front-line and professional staff, who can actually manage that interface with people in a more successful way. Certainly, the early evidence is that the outcomes are far better: people are calmer and happier and, actually, counter-intuitively it costs a little less money, often, because that upfront investment—we took that investment on ourselves—has made a massive difference. But in terms of the impact for individuals, if I can just give you a tiny example, a case that we often talk about is a lady who had withdrawn from life, really. She was behind her door and had dementia. Everybody had moved away in terms of any contact. Our traditional approach before might have been, 'She's not answering the door, she's not answering the door a few times, we'd better call the police and get the door broken down.' The person might be admitted into hospital or residential care. Because the workforce was empowered to say, 'Actually, what is going on for this individual?' they spent about four or five days talking to her through the letterbox: 'Let's see what's happening.' Bit by bit—and I'll go to the end now—this lady actually reconnected with her community, she got a mobile phone, she got a microwave, and she started being very, very independent. She spent three years before she sadly passed away being connected to what she thought were friends. Actually, it was our workforce, but they had taken this intentional approach. So for me, it's always the example that I use because I think it shows the difference between what we might have done before and what we're empowered to do now. But it's all about having the person at the centre and being really clear about who they are, what their identity is, and how we can—. So that, for me, is a very—. And it needs to be much stronger.

[523] **Mr Ayling**: I can't improve on Julie's example, because I think it's very powerful, but I think on the broader front in terms of person-centred care, for me that is partly about removing the stigma around dementia, as I said earlier. I know you've had evidence from others in relation to the importance of the Dementia Friends initiative, and I would really support that. It's so powerful, with quite a small targeted element of training. Again, speaking

locally, my corporate management team in Flintshire have all had the training around Dementia Friends. There are 270 staff within the authority, 300 within schools, and 400 people wider within the community of Flintshire who all have significantly more awareness around dementia as a result of that training, and that all adds to the ability to actually treat people in a respectful, person-centred way.

[524] **Dai Lloyd**: Okay. Moving on to Caroline, because you're building on the same sort of theme here, aren't you?

[525] **Caroline Jones**: Yes. Thank you, Chair. Good afternoon. When a person is suffering from dementia, obviously the care that they receive and the planning for their journey ahead is of paramount importance. I wonder if you could tell me if the draft strategy promotes the involvement of families and carers during this process.

[526] **Mr Ayling**: I think it does, but I think we all acknowledge, as Julie said earlier, that there's more that we can do to support the involvement of families and carers in the process. I mean, again, like all strategies of a similar vein, we're heavily reliant on our families and carers, and in this instance many of us are families and carers of people who have dementia. So, I think it's incumbent on us to improve that further. I do think we can help that by having those services in communities, rather than in institutions, in the main. Julie spoke about an example in Monmouthshire where that's happened. Again, we've had real success in that in terms of working with third sector colleagues, with local churches and with local businesses to actually make sure those services are there in ways that are accessible to people. Interestingly, the issue around resources is one where sometimes you see interesting trends, because we've actually, in my county, seen a reduction in some of the demand for traditional day services as a result of there being popular community-led dementia cafes and other community-led approaches that support families. So, hopefully that starts to answer your question.

[527] **Caroline Jones**: Yes. And with regards to the voluntary sector then, as well—regarding the voluntary sector's involvement.

[528] **Mr Ayling**: The Alzheimer's Society and carers organisations are an absolutely—for ourselves—fundamental part of that approach. In terms of resources, I would say that we as a community are going to get the best possible value out of investment by supporting those colleagues in this area

around dementia support and dementia care.

[529] **Ms Boothroyd**: I do think, just adding to that, there is a real—. It's very important, I think, that we recognise that carers may not always be equipped for the journey ahead. I do think there is—. Certainly, our learning through training staff—often staff have said to us we need to give this training to people who are supporting and caring for people, because they need to have that same level of knowledge to feel supported to be able to continue. So that's something that I think we've got to invest in: what would support and training look like for informal carers, so that they actually have—? It often is a shock, and it's often something that people are not equipped for. So, it's how we can build some resilience for people to be able to know where to go—whether it's a dementia cafe, whether it's a level of training. I think that would be really useful.

14:30

[530] **Caroline Jones**: Thank you.

[531] **Ms Alleyne**: Just quickly to reinforce Julie's point. We recently undertook some research with the sector, looking at the improvement priorities moving forward, and one of the key messages that came back was around, in certain ways, seeing carers not as part of the formal workforce, but seeing them in the workforce and providing not just support but training opportunities. One of the issues picked up, I think, within the strategy, is training around dealing with aggressive behaviour, for example. So, how do we equip our carers to ensure that they've got the right experience or skills in that? So, it's just reinforcing that that was a message that came from the whole sector in terms of supporting carers not only in terms of dementia, but more broadly moving forward as well.

[532] **Caroline Jones**: Thank you.

[533] **Dai Lloyd**: Grêt. Symud ymlaen i Jayne nawr.

Dai Lloyd: Great. Moving on to Jayne now.

[534] **Jayne Bryant**: Thank you, Chair. I think the points that you've both raised on training carers who've come into it, I think, are very valid, and I think you've made a very powerful point there. Just moving on to the support for carers, we've had evidence criticising the limiting scope of the high-level performance measure, regarding carers assessment and support plans. Age

Cymru, I think, have said that,

[535] ‘with no mechanism to monitor the impact and delivery of the [carer’s support] plan, an increase in the number of plans is meaningless.’

[536] What would your views be on that?

[537] **Ms Boothroyd**: It might be the wrong measure—that would be my first thought. Often what we find is that some of the measures that we have don’t actually measure the right things. The evidence that we get back from carers is that sometimes they don’t recognise themselves as carers and don’t want to be put in that box that has the label ‘carers’ on it, therefore we can’t count it. A lot of people, I think, picking up on Neil’s point, are accessing support through support groups, through different mechanism, whether that’s a dementia cafe or whether that’s support in the community. We may be facilitating that and we may be involved, but we’re not counting it as a stat. I think it’s a valid point that Age Cymru are making, but, actually, to count everything so that we could justify whether we’ve made an impact is probably the wrong bit of the measure. I think some of the work that we’ve been looking at, particularly around the information, advice and advocacy service, which is part of the Act, is that actually people access support in many, many places, and actually it’s quite difficult to quantify and count.

[538] So, it’s the right challenge, but it’s because it’s the wrong measure, and, in effect, we need to have better measures or we need to be able to put other evidence on the table that says—. So, for example, we hold a database of carers, and there are about 800 people who are on that, who receive a newsletter, who come to events. They don’t want to be caught as a stat in a measure that says, ‘I’ve had a carer support plan’. That’s not helpful, so what we do is we say, ‘We’ve got 800 carers who’ve had this sort of support’, but that doesn’t fit in the box. So, I think it’s a very complex area. If you want assurance from a number, there’s a lot of context underneath it that I think we’ve got to understand more.

[539] **Jayne Bryant**: Just on the suggestion that carers are experiencing tighter eligibility criteria for accessing support services—you know, things like much needed respite services—do you have any views on that?

[540] **Mr Ayling**: The evidence that I’m aware of in Flintshire and throughout my colleagues is that actually the Social Services and Well-being (Wales) Act 2014 should have actually, in many ways, increased the access to services in

terms of eligibility criteria. Certainly, we haven't seen any evidence that we've reduced that. The social services and well-being Act, if anything, was around actually offering support on people's own terms. So, actually, the, 'What's important to you?' conversation is something that we take forward in north Wales, and other colleagues do. Clearly, I'd be interested to know about the evidence behind that question, but I wouldn't say that that has been the case in relation to the social services and well-being Act. I think one thing I would say is that Naomi mentioned Dewis, around that as a very user-led and community-led approach to actually giving people more information and more advice so that they can actually make those connections within the communities, and that's probably something—. I know there's a lot of specific information on that system around dementia, and that is a resource that we should seek to actually use. So, yes, that would be my response.

[541] Around carers, and in terms of the actual—. You know, in trying to get a performance indicator that makes us perform better, I would support what Julie said. It's often tempting to try and pigeonhole a particular area of activity and, actually, what's important for me, my colleagues and my voluntary sector colleagues in Flintshire is how we support carers as a whole, in terms of the whole area of service—both people who support people with dementia and in other areas where people are caring.

[542] **Jayne Bryant:** So, what are your views on the national approach to respite care? Do you think that that is something that you would support?

[543] **Ms Boothroyd:** I was just going to pick up on the—. I think I'm probably understanding where this might be coming from, which is that, actually, often, when carers do come forward there is, and can be, a lack of the right respite available. It isn't that we're not willing to sponsor or support; it's that actually the provision isn't in the right place or it hasn't been developed enough. Certainly, we've been having conversations with carers about what that looks like. It doesn't necessarily just mean two weeks in a residential home, because actually that may not help. It might be that we need to sponsor some support in somebody's own home. So, I can understand why people might think—. But it might be to do with the gaps that we have in some of the provision that people require.

[544] **Dai Lloyd:** Okay. Lynne.

[545] **Lynne Neagle:** The document is quite light on actual concrete performance measures anyway across the board. Do you think, then, it would

be better to have more figures in there to tie the Government into progress, taking this forward across the board?

[546] **Mr Ayling:** I think, as Julie said, we need to get the right measures of performance, and I think those need to be broadly based. I think the Government, or Welsh Government, needs to work with other partners to actually develop those in partnership. I think it's not necessarily the best approach to actually say, 'In this context, this is what's going to happen, you've got to comply with it'. I think we need a broad-based approach to actually improving the lives of people who have dementia and their carers and supporters, and actually having quite tight PIs I'm not sure will take us there, to be honest. So, that's my honest response.

[547] **Lynne Neagle:** Predictable from local government, I've got to say. [*Laughter.*]

[548] **Mr Ayling:** Okay, there we are.

[549] **Dai Lloyd:** Moving on to palliative care.

[550] **Ms Alleyne:** I was just going to say that you can have some measures that include numbers and figures, and I think what's missing from some of these measures is that it's not clear where the baseline is—so, where we're moving from, where we want to go to and in what time frame. Some of the measures are certainly not SMART in terms of being able to be clear about that progress, but I think some of the measures—well, not necessarily measures, but there is importance around the qualitative input as well, because this is about improving people's experiences, and the figures or stats won't always give that. So, I think there is something about needing to tighten up some of these measures, and very few of these performance measures actually link to the key actions in the document. So, there is something about how we're going to measure a lot of the key actions, a lot of the aspirations within it, but I think there is something where we need to actually talk to people and find out what their experiences have been as well.

[551] **Lynne Neagle:** Thank you, that's very helpful.

[552] **Dai Lloyd:** Okay. Carry on.

[553] **Lynne Neagle:** Our previous witnesses raised concerns about the provision on palliative care in the document. They said that they thought

there should be a distinction between palliative care and end-of-life care. Have you got a view on how effective the strategy is likely to be in improving things in that area?

[554] **Mr Ayling:** I clearly didn't hear the discussion, so I don't know what their reasoning was for separating those two out.

[555] **Lynne Neagle:** I think they were saying that dementia is a terminal illness and that the palliative phase can go on for a long, long time, and that is different from the end-of-life phase, which could be just a few days or a couple of weeks.

[556] **Mr Ayling:** Well, in that case, as I understand it better, I would support that. Quite clearly, the end-of-life care in relation to how people are sensitively supported in those last weeks and months of life is a fundamentally important part of the strategy and for us in our services. We have a partnership approach in Flintshire, which, I think, is the six steps towards care. That is another partnership with health and with the independent sector, around that. But, quite clearly, when people could be supported through living with dementia for years and, indeed, sometimes five, 10 years, quite clearly, that is very different from the end-of-life support.

[557] **Dai Lloyd:** Ocê, mae gennym ni bum cwestiwn mewn pum munud yn sylfaenol, so, os caf i ofyn i'm cyd-Aelodau fod yn fyr efo'r cwestiynau a gofyn yn garedig i chi fod yn fyr efo'r atebion hefyd. Jayne, ti sydd â'r cwestiwn nesaf.

Dai Lloyd: We have five questions in five minutes essentially, so I ask my fellow Members to be brief with the questions and ask you to be brief with the answers as well. Jayne, you have the next question.

[558] **Jayne Bryant:** Thank you. We touched on this a little bit, about the dementia-friendly Wales. I'm very pleased that, in Newport, we're working really hard to try and get a dementia-friendly Newport, and I've got a dementia-friendly office as well, so I really think it's very important. But, do you think that that will go enough of a way to change the attitudes that we need to change to help with dementia?

[559] **Mr Ayling:** I'll start. I don't think it will in itself, no. I think it's a really helpful measure, which actually starts bringing about some basic realisation about the issues, and then we need to build on that and actually achieve

further awareness. Another practical example in my area is that we have a cinema in a particular town in Flintshire—I won't name it—but there were issues with the mat. People with dementia were actually terrified going into the cinema—they had a big black mat and, in a sense, people thought they were falling down a hole. We've had the same issues in shops, in businesses, in local towns and, actually, businesses have changed simple things around that, which has made considerable change and improvement in people's lives. Those are the small practical examples that we need to move on, you know, month on month, year on year. Dementia Friends is a really fantastic advance and we need to improve that. But, I suppose, as a director of social services, my awareness has improved, and colleagues who are senior officers and members, their awareness around dementia has improved. I've seen a lot of positive change, which I think is really quite encouraging.

[560] **Ms Boothroyd:** I would just—

[561] **Dai Lloyd:** Sorry, this is covered by a similar question from Caroline.

[562] **Caroline Jones:** Yes. What are your views on the provisions in the draft strategy for improving the training of people working in dementia services and how they manage challenging behaviour? It's partly been answered by Julie.

[563] **Ms Boothroyd:** I think one of the things that I would say is that the terminology is a bit of an issue, so 'challenging behaviour' isn't something that we necessarily recognise. It's actually people living with altered, different realities. I think there has to be some language refresh around this because, actually, it's not helpful if people are seen, with dementia, as being challenging, when actually they're not. They're having some episode that's actually quite difficult at that moment in time. How do we support our staff to recognise that and actually deal with that in a meaningful way that doesn't label somebody as 'wandering', 'challenging'? Those are things that we're trying really hard to move away from, because they're not about a person, they're about a label.

[564] **Ms Alleyne:** I think there's quite a bit in the strategy around training, which is welcomed in terms of awareness raising and, obviously, referring to the needs for specialist posts and specialist training. I think what I particularly welcomed as well is that much broader approach of looking at our colleagues and our partners across public service and all parts of society in terms of what we can do. I think that comes back to partly answering your

question about the awareness raising, but also about what each of us as individuals could do to assist people should we come across them. I think it would be helpful to review what training is out there now—does that fit with the strategy and the ambition moving forward, and have different levels for different people in the roles they undertake? But I think there's a lot in there that we can build upon.

[565] **Dai Lloyd**: Y cwestiwn olaf— Rhun.

Dai Lloyd: A final question from Rhun.

[566] **Rhun ap Iorwerth**: A quick response from the three of you, just to wrap up on resource implications of this strategy. We have a saying in Welsh that is '*diwedd y gân yw'r geiniog*'—literally 'the end of the song is the penny', but it can be translated as 'it all comes down to money'. I know, in your submission, you say that the strategy's very quiet on financial resource implications. What are your thoughts on what the strategy means in terms of the financial resources that you'll be expected to put in, and also on your capacity—your capacity as social service departments and also the social care sector?

14:45

[567] **Ms Alleyne**: I'll start. Very quickly, I think, obviously, resourcing is always a big issue. The strategy starts by setting out how much has been invested and in what areas, and a lot of that is in hospital settings. I couldn't find anything that's gone in specifically around social care within that. But I think there are also actions within the strategy that we can take. Because it's about cultural change, it won't necessarily require additional resourcing. There are things that we could be doing—or how we look at them through a dementia lens, what we're already doing—but there are some aspects of the strategy that may need some additional resources and pump-priming.

[568] **Rhun ap Iorwerth**: Does that frighten you, seeing as those resources aren't there?

[569] **Ms Alleyne**: It depends on that oversight and how it'll be taken forward, because, going back to before, some of those key actions and the performance measures, it's not really clear how some of all of that will be delivered, moving forward. So I think I'd like to see that there are continuing conversations about what those resources are, and when there is a need for additional resources, we can have some discussion around where they come

from. But we could also look at how we use our collective resources better in some instances in the strategy, as well.

[570] **Ms Boothroyd:** I do think, as well, that actually a lot of work is in train, in progress and well developed, so it's quite hard to say, 'What would the pound sign look like?' because everybody's in a slightly different place and may use resources in a different way to address this. My view is that it comes down to leadership, passion and commitment to wanting to deliver around this. Some of this you can do for free and you can do without resource; I think we'd need to size what would be—. I think the bit that I know is resource intensive is training. That isn't money that we have, and when we invest it, it's quite a bit of money, but it's a good investment.

[571] **Mr Ayling:** My answer is: there is capacity in authorities; we've had to make sure that there's capacity in authorities because it's such a crucial agenda, and we've used resources from other elements. In terms of the overall resource element, whatever you spend in institutions, spend twice as much in the communities, as you'll get better value out of it and we'll get better value out of it, and the third sector is where to invest, in my view.

[572] **Rhun ap Iorwerth:** Thank you. Diolch.

[573] **Dai Lloyd:** Diolch yn fawr ichi. Dyna ddiwedd y sesiwn dystiolaeth. A gaf i ddiolch yn fawr ichi unwaith eto am eich cyfraniad ar bapur yn y lle cyntaf, cyn y cyfarfod yma, a hefyd am ateb y cwestiynau mewn modd mor raenus ac aeddfed? Diolch yn fawr iawn i chi'ch tri am eich presenoldeb y prynhawn yma. Diolch yn fawr iawn ichi.

Dai Lloyd: Thank you very much. That's the end of the evidence session. May I thank you once more for your contribution on paper in the first instance, before this meeting, and also for answering the questions in such a mature way? Thank you very much for attending this afternoon. Thank you.

14:47

Papurau i'w Nodi
Papers to Note

[574] **Dai Lloyd:** Symud ymlaen nawr i eitem 8, a phapurau i'w nodi. Mae yna bapurau i'w nodi yn fanna:

Dai Lloyd: We now move on to item 8, which is the papers to note. There are papers to note, there: additional

gwybodaeth ychwanegol gan Gomisiynydd Plant Cymru ac mae yna hefyd lythyr gan Weinidog Iechyd y Cyhoedd a Gwasanaethau Cymdeithasol ynghylch Bil Iechyd y Cyhoedd (Cymru). Mae yna wybodaeth ychwanegol gan Goleg Brenhinol y Meddygon ynglŷn â Bil Iechyd y Cyhoedd (Cymru) hefyd, a hefyd gwybodaeth ychwanegol gan Crohn's and Colitis UK, hefyd ynglŷn â Bil iechyd y cyhoedd. Y papurau yna i'w nodi. Diolch yn fawr.

information from the Children's Commissioner for Wales and there is also a letter from the Minister for Social Services and Public Health on the Public Health (Wales) Bill. There is additional information from the Royal College of Physicians on the Public Health (Wales) Bill, and also additional information from Crohn's and Colitis UK also regarding the Public Health (Wales) Bill. Those papers to note. Thank you very much.

Cynnig o dan Reol Sefydlog 17.42 i Benderfynu Gwahardd y Cyhoedd o'r Cyfarfod
Motion under Standing Order 17.42 to Resolve to Exclude the Public from the Meeting

Cynnig:

bod y pwyllgor yn penderfynu gwahardd y cyhoedd o weddill y cyfarfod yn unol â Rheol Sefydlog 17.42(vi).

Motion:

that the committee resolves to exclude the public from the remainder of the meeting in accordance with Standing Order 17.42(vi).

Cynigiwyd y cynnig.
Motion moved.

[575] **Dai Lloyd:** Eitem 9: cynnig o dan Reol Sefydlog 17.42 i benderfynu gwahardd y cyhoedd o weddill y cyfarfod. Pawb yn cytuno? Diolch yn fawr.

Dai Lloyd: Item 9 is a motion under Standing Order 17.42 to resolve to exclude the public from the remainder of the meeting. Are we all content? Thank you very much.

Derbyniwyd y cynnig.
Motion agreed.

Daeth rhan gyhoeddus y cyfarfod i ben am 14:48.

The public part of the meeting ended at 14:48.